07-02625 Daniel J. Hamilton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

7 1			
State of Maryland	Department of He	ealth and Mer	ntal Hygiene

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24110. 5. (1411111		1- For State Registrar	010	ite or Marylar	•	rtificate of		na meni	,,,	∠ U : Reg. No.	01 1000
Physicia Medical Examir	n/	1. Decedent's Name Daniel			•				2. Date of De Month April 6, 2	ath Day Year	3. Time of Death 1225 hrs
		4a. Facility Name (ii 8426 Wood		, give street and num	ber)	4	b. City, Town, o			4c. County of I	
Funeral Director		5. Social Security N 218-29-43		6. Sex 7	Age (In yrs. I	• • • • • • • • • • • • • • • • • • • •	If Under 1 Ye	ear If Under ays Hours			e. 8irthplace (State or oreign MD
w any			10b. County	7	1	, Town or Locati					10d, Inside City Limits
aryland 8a-f sho	Director	MD 10e. Street and Nur		Arundel		Millersv	111E 10f. Zip Code			10g. Citizen of What	1 Yes 2 X No
h the Ma 33a or 21 notified		8426 Woo	odland	Road			211	108		US	Α
r death wit or items 2	Funeral	11. Marital Status 1 X Never Marrie		1 Yes		If Ye	es, specify Cuba	an, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	White, e	
ours after	d by	3 Widowed 15. Decedent's Ed		rced If Yes, Give Year or Dates: fy only highest grade	completed)	16a. Decedent		ation (Give k	ind of work done	Specify: 16b. Kind of Busin	White less/Industry
1036 vithin 72 h ene. er than "n	Completed	Elementary/Seco		College (1-4	or 5+)	auring mo	st of working lit Stude	ent			lege
21215-0036 vold be filed within 7 Mental Hygiene. marked other than ic event, the Medic	Be ငိ	17. Father's Name (Roger Pa				.			s Name (First, Middle, etta Eliza		illeri
MD 21 ad 2 should I alth and Mer m 27 is mar	-	19a. Informant's Na:		ip (Type, Print) ilton/Moth	ner		Address (Stre		ber or Rural Route Nu	mber, City or Town, SVille, M	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33a or 28a-f show any injury or other traumatic event, the Michael Examiner must be notified at once.		20a. Method of Disp	oosition X Cremation	3 Removal from	20b.	Place of Disposi crematory or oth tro Crei	tion (Name of c		April 10 2007	20c. Location - Ci	
Baltir permit I Departme Importa	Ī	21. Signature of Fur				l Ba	ame and Addre	& Sons	s. P.A. S	everna Pa: everna Pa:	rk Funeral Hom
Physician /Medical	7	23a. Part I. Enter the failure. List onl			sed the death	. Do not enter th	e mode of dying	g, such as ca	ardiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (F or condition resulting		Due to (or as a o				-			Death
	ner	Sequentially list cor if any, leading to im cause. Enter Under	mediate	b. Due to (or as a co	onsequence o	of):					
ited d ansit	Examine	(Disease or injury the events resulting in o	nat initiated	Due to (or as a cod.	onsequence o	of):	· .				
760, ficate be executed g physician and the burial - transit	dical	UNPENDED IF FEMALE:		AMENDED							
Box 68760, e death certificate be the attending physic of for use as the burned for use	sician	IF FEMALE: 23b. Was decedent past 12 months	?	4 Pregnar	h at at time of de	2 Fet	al death 3 ner (Specify)	Ectopic	pregnancy	23d. Date of de Month	livery Day Year
O. Bc at the des d by the a	影	Part II. Other signif		J OTIKITOW		esulting in the u	nderlying cause	e given in Par	rt I. 23e. Did		te to the cause of death?
ds, P.C equires that	ted by								1 Ye		Probably 4 Unknown re autopsy findings available
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	Completed								1 Ves	ormed? dea	or to completion of cause of oth? Yes 2 No
/ital ysician:	o Be	25. Was case referr examiner? 1 ✓ Yes	ed to medical	Hospital: 1 Inp	patient 2	ER/Outpatient		Other	Check only one) Nursing Home 5	Residence 6	Other: Scene
on of Vi ending Physi ath. or: After this	⊢	27. Manner of Death 1 Natural	5 Pendi		lay, Year)	28b. Time of Ir FOUND: 1217 hrs		jury at Work?	Subject shi	how injury occurred of self	
Divisitial or Atti	Certification:	2		not be 28e. Place		ome, farm, stree	t, factory, office	e building, etc	or Town.		or Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filler	Medical C	29a. Certifier 1		niner: On the basis of	examination a				ce, and due to the cau		
To will To cor	Me	29b. Signature and	, A	and manner sta	rted.			nse number			(Month, Day, Year)
,	-	30. Name and addre		vho completed cause		n 23a)	0.0			April 7, 2007	
3		Tasha Gree	nberg MD	Assistant Me	dical Exam	niner 111	Penn Street	t, Baltimor	re, MD 21201		
Sta Registi		31. Date filed (Mont.	h, Day, Year)	2007 32 keg	strar's Signati	k L	12				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	arylan		artment rtificate			and M	lental H	ygien Reg. N	Z U U	17	135	502
	Physici	an	1. Decedent's Name (First, Middle, Las	-							2. Date of D		² 2007	Year	3. Time (
	/Medic	cal	Zelda Marie John 4a. Facility Name (If not institution, give)		4h Cih.	Tour or	Location o		Aprii		lc. County	of Donth		L W
7	Examir	ier	Charlotte Hall Ve						e Hal				St. Ma			
	Funeral Director		5. Social Security Number 6. S			last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of E (Month, I April	Sirth Day, Yea 5, 1	924	9. Birth Was	place (State hingto	or Foreign
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation		-						10d. Inside (City Limits
	be filed within 72 hours after death with the Maryland nat Hygiene. Id other then "naturel", or iteme 23a or 28s-f ehow event, its Modical Exemplast must be redified at	ro	Maryland St. Mar	rv's		ort To										s 2 <u>X</u> No
	r 28s	Funeral Director	10e. Street and Number	., .			10f. Zip	Code				10g. C	Citizen of W	hat Cou	ntry?	
	th with	aiD	7750 Carol Rd.				206	677				I	JSA			
	dea	Iner	11. Marital Status	12. Was Deceden Armed Forces		.S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spi	ecify Yes or I Rican, etc.)	No-		- Ameri k, White	can Indian, etc.	
36	or it	Y.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give 2 Year or Dates:	No		1□Yes 2	**	Specify:				Specify:	Wh	ite	
8	ture	ed t	15. Decedent's Ed			16a. Dece	dent's Usua	I Occupa	ition		-	16b.	Kind of Bu	siness/Ir	ndustry	
21215-0036	hin 72	piet	(Specify only highest gra	de completed) College (1-4or	5+)	(Give	kind of wor DO NOT us	rk done d se retired	luring most)	t of work	ing					
21	ed withi	Completed by	Elementary/Secondary (0-12)		,	Clerk	Typis	st					Gove		nt	
Maryland	should be filed within the Mental Hygiene. marked other the matic event, the Mental Men	Be	17. Father's Name (First, Middle, Last) George Franklii								<i>(First, Midd</i> zabeth			e)		
7	should nd Men marke	5	19a. Informant's Name/Relationship (19h Maili	na Address	(Street a			A Route Nun			State Zi	n Code)	
Ma	nd 2 shoulth and 27 is m.		Stephen Johnson/So	on		7750	Caro.	1 Rd	., Po	rt T	obacco	, MI	206	77	- 0020/	
re,	Pages 1 end ment of Heeltl ant: if item 2; ury or other t		20a. Method of Disposition			Place of Dispo cemetery, crea	osition (Nam	ne of ther place	9)		Date April	20c.	Location -	City or T	own, State	
ij	Page nent c ant: If ury or		1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			inity				ns	21, 20	007	Walde	ort.	MD	
Baltimore,	permit. Pages 1 end 2 should Department of Heelth and Men Important: If item 27 is marks eny injury or other treumatic 805.		21. Signature of Funeral Service Licer	See ST			2. Name an			וע	insfie	eld-E	Echo1s	s F.	н., Р	-
	70 = 9 d		23a. Part1. Enter the disease, or com								Rd., (lotte	Ha1	1, MD	
8760,	death certificate be executed Read ion use as the buriat-transit A for use as the buriat-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ASK Due to (or a b. Ch NON Due to (or a c. All C Due to (or a d. My P.	s a consequence of the consequen	tion Juence of): He v Juence of): Scle Juence of): Superior Juence of):	om noti	bod	um ey to arc	op	enic	zul	ar (dis	Onset and	
P.O. Box 68	that the death certifical ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. tf yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	il déath 3[⊒Ectopic pro □ Other (spo					-	23d. Date Mor		rery Day	Year
	8 5 8		Pan II. Other significant conditions of	ontributing to death	but not res	ulting in the u	inderlying ca	ause give	n in Part I.						the cause of	/
Vital Records,	w requir been si should	Completed by	super 11 pic	1emia	`						1[Yes	2 No	3 Pro	bably 4	Unknown
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a	ilcian: The L certificate ha rector, page 3		Hy Po	thyn	oidi	sm					1 ☐ Yes	2		Yes	2□ No	
₹		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	ient 2	ER/Outpatie	nt 3 DO	Othe	\		n <i>(Ch</i> eck onl) me 5 □ Re		e Doth	ne (Snoo	(6.1)	
10	g Phys er this eral di	-	27. Manner of Leath	28a. Date of Inj (Month, D	ury	28b. Time o		8c. Injury Work			28d. Describ				·(y)	
Ö	Attending is death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident Investigation	n	ay 1 Gai)	Injury	м		Yes 2 □ I	No						
Division	l or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of It	njury - At h		reet, factory	, office			28f. Location City or 1	(Street own, Sta		er or Rui	ral Route Nu	mber,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Pt	ysician: To the bes	t of my kn	wiedne dest	h occurred	at the time	na data a-	d place	and due to the	000000	(e) 22d	nner or	stated	
	• Hos 124 h • Fun ietely	edical	(Check only 2 Medical Exar	niner: On the basis and manner s	of examina	ation and/or in	ivestigation,	, in my op	oinion, dea	th occur	ed at the tim	e, date a	nd place, a	and due	to the cause	(s)
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and twe of certifier	01_					number	_					Day, Year)	
			· Janel	Sam	w)		1148	090	X		41	18/	20	07	
			30. Name and address of person who	completed cause of	death (ligh	n 23a) (Type,	Print)	- Z)	L	red	101	1. 1	117	201	70
4	Sta	110	31. Date filed (Month, Day, Year)		rar's Signa	uue ature	aus	, /	nnc	21	real	nch	c 11	40	00	10
	Regist		APR 2 0 2007	S. DA		- M a										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Douglas Frank Jacoby April 2007 09:20 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 53 Director 220-58-8970 June 10, 1953 Illinois Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 TYes 2 TXNo Director Montgomery Derwood MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16913 Baederwood Lane 20855 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📈 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: White Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) the 5+ Teacher Education Ith and Mental Hygie 27 Is marked other i r traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be 1 Mental Philip Richard Jacoby Lois Adele Anderle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau
once. Laura Jacoby/wife 16913 Baederwood Lane Derwood, MD 20855 Pages 1 gment of He 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Chesapeake Crematory 04/13/07 Beltsville, MD 4 Donation 5 Dother (Specify) 21. Signature Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the dise ise, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SitenA Grand CARCINOME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): death certificate be executed physician and the burial-transit Exami Due to (or as a consequence of): Physician/Medical as 1 attending properties of the pr IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9□Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2No 1 🗌 Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy this certificate 1∏ Yes 2No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After thi funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 TYes 2 TNo within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Excertifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu 35 635 12,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin 15) JN

State

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division or Vital Records,

Registrar

31. Date filed (Month, Day, Year) **APR 13** 2007



OLNEY,

Dr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item 2	29detper M	arylag 870 0,€	8416/2 Certificate	0078 e of L	ab lth a Death	and Me		giene Reg. No.	007	13504
8	Physicia		1. Decedent's Name (First, Middle, Last) John W. Johnson							2. Date of De Month April	ath Day	Year 2007	3. Time of Death 3:15A
	/Medic Examin		4a. Facility Name (If not institution, give)	4b. City,	Town, or	Location of		TALLT		County of Deeth	
	1		Genesis Elder C	are @ S	ba Creel	k An	nap	olis			A	nne Ar	undel
	Funeral		5. Social Security Number 6. Sec		ge (In yrs. last birtho	fay) If Under Months		If Under a	Min.	8. Date of Bir (Month, Da	th	9. Birth	place (State or Foreign
	Director		215-32-0490 Susual Residence of Decedent	7 W 2 L	76 Yrs	S.			J	une 2	1 19	30 Mar	yland
	land ow		10a. State 10b. County	and the state of t	10c. City, Town o	r Location							10d. Inside City Limits
	Mary 1-1 sh	tor	Maryland Anne Ar	unde1	Annapo	olis							1 X Yes 2□No
	h tha	Director	10e. Street and Number			10f. Zip	Code				10g. Citiz	en of What Cou	intry?
	23£ c	rai	24 Parole St.			2	140	1			US	A	
	tams	Funeral		 Was Decedent Armed Forces? 	?	 Was Deced If Yes, spec 	ent of Hi ify Cubai	spanic Orig n, Mexican	gin? (Spec n, Puerto R	ify Yes or No ican, etc.))- 1	 Race - Ameri Black, White 	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 I If Yes, Give	953-61	1 ☐ Yes	No X	Specify:				Specify: B1	ack
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or Itams 23s or 28a-f show the Medical Evanitor norther notified at		15. Decedent's Edu	cation	16a. D	ecedent's Usua	I Occupa	ition			16b. Kir	d of Business/Ir	ndustry
215	hin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	In	Give kind of wor fe. DO NOT us	k done d e retired,	luring most)	t of working	g			
	ed wil	Completed	6th	0		orsegr	oom					se Stab	ole
pue	d 2 should be filed within 7 th and Mental Hygiene. 7 Is markad other than "r traumatic event, the Med	Be	17. Father's Name (First, Middle, Last)							(First, Middle,		,	
ryla	d Mer narka natic	L O	William H. John 19a. Informant's Name/Relationship (Ty		105.14	lailine Addansa	/Ca			C. Ar			- 0-4-1
Maryland	th and the and the and the and traum		Mildred Larkins	•								Town, State, Zi	b C00e)
	s 1 and 1 Health item 27 othar ti		20a. Method of Disposition	Taracer	20b. Place of D	Paro1 isposition (Nan	ne of		nnap Da	olis,		21401 ation - City or T	own, State
E O	Pages nent of I int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Maryla	crematory`or of and Ve			4-12-	-07	Cro	wnsvil	le, Md.
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with tha Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itams 23s or 28a-f show any injury or other traumatic event, it a Marolical Exa It or marke notified at ones.		21. Signature of Funeral Service License	96		Wm Name an	Addres	s of Facility	3ons	Morti	ıarv	, P.A.	
<u> </u>	90 E # 9		Jany B. Re	ear m	00483	821 W	est	St.	Anna	apolis	s, M	d. 214	01
B			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that cause ne cause on each li	d the death. Do not ine.	enter the mode	of dying	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Grono	ry arti	w du	114-6						
D	Examiner		1	Due to (or a	a fonsequence of	1						1	
	N E	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		a consequence of):								
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events										
8760,	oe exe	E	resulting in death) Last	Due to (or as	a consequence of):								
387	physicate I	edicai		1									
Вох 6	eath certific attending p for use as	√/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	of pregnancy						2	3d. Date of deliv	rary
m.	that the death ad by the atter detached for u	Physician/M	in the past 12 months?	4⊡Pregnant a	2 ☐ Fetal death t time of death	3 ☐Ectopic pro					-	Month	Day Year
P.O.	at the by th tache	hys	9 🗆 Unknown	9□ Unknown									-
S,	es the		Part II. Dther significant conditions con	/	1	1-	use give	n in Part I.		1 -			the cause of death?
ord	w requir been si should	ted	Perphit Unway 9	MM	1 Om	enlia				10	Yes 2]No 3∏Pro	bably 4 Dunknown
}ec	e law has b	Completed by								24a. Was autop	osy	prior to co	opsy findings available empletion of cause of
	stcian: The certificate rector, pag			<u> </u>						1 Yes	2 X No	death?	2ENO
<u> </u>	siciar	o Be	25. Was case referred to medical examiner?	lospital:	ο ΠΕΒΙΟ · · ·		Othe	-		(Check only o			
o	g Phys	-	1 Yes 2 No	28a. Date of Inju			Bc. Injury Work	4 (3)		e 5 ☐ Hesid 3d. Describe I		Other (Speci	<i>fy</i>)
ion	ittending F death. ctor: After the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ry Year) Inju	ry M		? 'es 2 □ N	No				
Division of	Hospital or Atteno 24 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm tc. (Specify)	, street, factory	, office		28	3f. Location (S City or Tox		Number or Rur	al Route Number,
	oital ours af												
	Hospita 24 hours Funeral etely filled	edicai	29a. Certifier 1X Certifying Phys (Check only one) 2 Medical Examin	sician: To the best ner: On the basis o and manner st	of examination and/o	eath occurred a r investigation,	at the tim in my op	e, date and inion, deat	d place, ar th occurred	d due to the dat the time,	cause(s) a date and	and manner as s place, and due t	stated. to the cause(s)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Med	29b. Signature and title of certified	and mainter at		29c	License	number			29d. Date	signed (Month,	Day, Year)
	1		D411			\mathcal{I}	38	958	8		Apri]	6, 200	7
	2X\		30. Name and address of person who co	mpleted cause of c	death (Item 23a) (Ty								_
)		Daliest Sinch	Sidhu 3	208 Crai	n Migh	Way	Sou	thw	el- f	lin.	Burne	MD21061
	Sta Registr		APR 1 7 20	32. Fegistr	rar's Signature	beach	, V						·

grove frendel

7. Age (In yrs. last birthday)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

Chestertown

3. Time of Death

2:29 a M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

Schaech

Approximate Interval Between Onset and Death

4840h13

Year

1909 Massachusetts

White

Reg. No.

APRIL 23 2007

4c. County of Death

U.S.A.

Kent

14. Race - American Indian.

Black, White, etc.

Public School

Smyrna, DE.

23d. Date of delivery

29d. Date signed (Month, Day, Year)

23/07

Day

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Month

System of Boston

2. Date of Death

State

within 24 hours e To the Funeral [

Medical

29a, Certifier (Check only one) 29b. Signature and title of

31. Date filed (Month, Day, Year) Registrar

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

KEOUGH

Chester River Hospital Center

6. Sex

KATHARINE

Physician

/Medical

Examiner

Neil Stoddard, M.D. 100 Brown St. Chestertown, MD. 21620 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

50996

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland / Depa	artment of Health and M rtificate of Death		ene () () 7	13506
	Dharini		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Deborah	Anna Kline			22, 2007	5:30 p. M
	Examin		4a. Facility Name (If not institution, give s	· ·	4b. City, Town, or Location of Death		4c. County of Death	
			3429 Brethren Chu		Myersville		Frederic	
	Funeral Director	!	210-30-4141	M 257 F 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	year) 9. Birthp Cour 1949 Mar	place (State or Foreign htry) yland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			Od. Inside City Limits
	f sho	ō	Maryland Frederic	n le 36				1 □Yes 2t □No
	the 28a	rect	10e. Street and Number	ck Myersvi	10f. Zip Code	100	. Citizen of What Cour	
	3a or		3429 Brethren Chur	ch Road	21773		USA	
	ms 2	Funeral Director	11, Marital Status	2. Was Decedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (Spo	ecify Yes or No-	14. Race - Americ	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I've Medical Eval. It at Ireast be rediffical at ODGe.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 ☐ No	lf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, Specify: Whi	
Maryland 21215-0036	2 hou	ed	15. Decedent's Educ	cation 16a. Dece	dent's Usual Occupation	16	ib. Kind of Business/In	
75	n n	plet	(Specify only highest grade	(Give	kind of work done during most of work DO NOT use retired)	na	ederick Co	
2	r tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) Schoo	1 Bus Driver		blic Schoo	-
힏	i Hyg othe	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Ma	iden Sumame)	
a	Ald be Menta rked ric ev	To B	Richard Douglas	DeLauter	Dolores	Adelaid	e Brown	
ary	shot and N s ma	_	19a. Informant's Name/Relationship (Type	pe, Print) 19b. Mailir	ng Address (Street and Number or Rura	I Route Number, C	City or Town, State, Zip	Code)
Ξ	alth a alth a 127 is		Angie Kline/daugh	ter 3429	Brethren Church Ro	oad, Myer	sville, MD	21773
ē,	item item othe		20a. Method of Disposition	20b. Place of Dispo		The state of the s	c. Location - City or To	
ltimore,	Page Bent c nt: ff iry or		1 ∑Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		5, 2007	Myersville	, Maryland
a	mit.		21. Signature of Fill eral Service Opense	e 22	2. Name and Address of Facility	504	Main Stre	et
m	Ded E		all thete	,	Ricketts Funeral		rsville, M	
			23a. Part1. Enter the disease, or complic	cations that caused the death. Do not ent				Approximate
	Physician [*]	l N	shock, & Heart failure. List only on Immediate Cause (Final	1				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	ncer			
	Examiner			200 10 (0. 20 2 00. 00400. 000 0.).				
	-100	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
8	be executed sician and burial-transit	Examiner	that initiated events				3	
ó	an ar rial-tı		resulting in death) Last	Due to (or as a consequence of):				
8760,	icate be physicia s the bu	dicai	d					
9	rtifica ng ph as th	led	ICCENAL C					Ti di
ŏ	The law requires that the death certificate be executed the heat been signed by the attending physician and one 2 should be detached for use as the burial-transit	Physician/Me	230. Has decedent pregnant	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐	Ectopic pregnancy		23d. Date of delive	
m m	dea he att	sicie	in the past 12 months? 1 ☐ Yes 2 🔀 No		Other (specify)		Month	Day Year
o.	at the de by the a	hy	9 Unknown			,		
	es that igned b	by F	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
ב	w require been si should b	ted				1 🕱 Yes	2 ☐ No 3 ☐ Prot	oably 4 Dunknown
Records,	e law n has be e 2 sh	Completed				24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
_		mo;				performe	d? death?	
Vital	slcian: Th certificate rector, pag	Bec	25. Was case referred to medical		26. Place of Death	(Check only one)	3.10	
<u> </u>	yslo	To	examiner? 1 ☐ Yes 2 💢 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3□ DOA Other: 4□ Nursing Ho	me 5 Residence	ce 6 Other (Specif	y)
Division of	ng Pt ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how		
<u>Ö</u>	andir sath. or: Al	atic	Natural 5 Pending investigation		M 1 ☐ Yes 2 ☐ No			
Š	er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town,	et and Number or Rura State)	al Route Number,
	ital or saft	Cer		3, , , , , , , , , , , , , , , , , , ,				
	To the Hospital or Attending Physician: white 24 hours after deals. To the Funeral Director: After this certifics completely filled in by the funeral director,	edical	29a. Certifier (Check only one) Certifier 2 Medical Examin	ician: To the best of my knowledge, death her: On the basis of examination and/or in- and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
	To the To the To the To the Comp	Me	29b. Signature and title of certifier		29c. License number	290	. Date signed (Month,	Day, Year)
			· Ma	mo	D0058726		4-24-07	+
			30. Name and address if person who con	mpleted cause of death (Item 23a) (Type,			1 2 1 -	
	12		3000 - D	Ventrie Ct. Mye	rsville MD 2	1773		
	Sta	tė	31. Date filed (Month, Day, Year)	32 Registrar's Signature	<i>a</i>)			
	Registr	ar	APR 2 6 200	Registrar's Signature	all!			

			For State	State of	of Marylan				nd Mental Hy	/giene		
		j.	Registrar	f_ t = -43		Cei	rtificate of	Dealii	2 Date of D	Reg. No.	2007	107507
	Physicia	an	Decedent's Name (First, Midd.	e, Last)					2. Date of Di Month	Day		3. Time of Death
	/Medic				ngmore				April			11:55p ^M
	Examin	er	4a. Facility Name (If not institutio		ımber)		4b. City, Town,		Death		County of Death	
-	in a		23005 Abell S	treet 6. Sex	7 Ann //n	la at hirthday	Leonard If Under 1 Year		Hrs. 8. Date of Bi		Mary's	
ш	Funeral		5. Social Security Number	1.XIM 2□F	7. Age (In yrs.	Yrs.	Months Days		Min. (Month, D	ay, Year)	Coui	
	Director		215-36-3659 Usual Residence of Decedent		65				07/17	/1941	. Mary	Land
	land		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					Od. Inside City Limits
	Mary f she	ō	Maryland St. M	ary!e	Lagi	nardtov	m					1 XYes 2 No
	the 28a	Director	10e. Street and Number	ary s	псол	nai deov	10f. Zip Code			10g. Citi	zen of What Cou	ntry?
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at		22005 Aboll C+				20650			IIni t	ed State	2.5
	leath ns 2: mus	Funeral	23005 Abell St	12. Was Dec	cedent Ever in U		20650 Was Decedent of	Hispanic Origin	n? (Specify Yes or N		14. Race - Americ	
10	r iter	교	1 ☐ Never Married 2 ☐ Mar	ried Armed F	2 🗌 No				Puèrto Rican, etc.)		Black, White,	etc.
9	urs a al", o	þ	3 ☐ Widowed 4 Divorced	If Yes, G	iive Dates:		1 ☐ Yes 2 🖾 No	Specify:			Specify: Wh	ite
21215-0036	2 hou	Completed by		nt's Education	,	16a. Dece	dent's Usual Occi	upation	fadda.a	16b. Ki	nd of Business/In	
75	in "n Medi	ple	(Specify only higher Elementary/Secondary (0-12)	est grade completed,) (1-4or 5+)	life.	kind of work don DO NOT use retir	e during most o. ed)	t working			
27	yiene giene rr tha	E O	12	Concgo	(1 401 01)	Distr	ict Cour	t Commi	ssioner	Cour	nty Gove	rnment
b	othe othe	Be C	17. Father's Name (First, Middle	, Last)				18. Mother's	Name (First, Middle	e, Maiden	Surname)	
a	Ild be Tenta rked iic ev	To E	James Abell Lo	ngmore				Rose	Theresa A	1vev		
Maryland	shot s mai	Г	19a. Informant's Name/Relation			19b. Maili	ng Address (Stree		or Rural Route Num		r Town, State, Zip	Code)
Σ	alth a		J. Abell Longm	ore/Broth	er	P.O.	Box 671	, Leona	rdtown, M	aryla	and 206	50
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		20b. I	Place of Dispo	osition (Name of matory or other pl	1	Date	_	cation - City or To	own, State
E	Page nent c nt: If		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (n State			i i	4/19/2007	Leon	ardtown.	Marvland
aĦ	mit. Sartin Sorta Inju		21. Signature of Funeral Service	Lizensee					Brinsfiel			
ä	Der Imp		Edward N. Br	insfield,	Jr. MO							20650
ķ.	100		23a. Part1. Enter the disease, of shock, or heart failure. Lis									Approximate Interval Between
	Physician		Immediate Cause (Final	t only one cause on	CHEM IC	MEC	Rosis K	ion for	0			Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	o (or as a consec	uuence of):	4	0.00	an Culor des			4 montas
	Examiner			Ai	74EROSI	luotu	PERINA	iral VAS	Culor des	EON	Ex trum	year
	STATE OF	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	for as a consec	THENCE of).						
	uted	Examiner	Cause (Disease or injury that initiated events	1 . #	unuche	les fu	of cenia					years
Ó	execting an and rial-tr	Exa	resulting in death) Last	Due t	(r as a consec	quence of):	7					4.
8760,	cate be executed physician and the burial-transit	dical		Cd. Do	iobeli	Mill	of ania					gurs
Φ	tifica ig ph	ledi								1	1	/
Вох	h cer endin use	1/2	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregn		⊒Ectopic pregnan	201		4	23d. Date of deliv	rery
Ω.	deatle atte	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Preg	birth 2□Feta gnant at time of o		☐ Other (s <i>p</i> ec <i>ify)</i>				Month	Day Year
P.0.	t the by the ache	hys	9 □ Unknown	9□Unk	nown							
Ψ,	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	inderlying cause o	given in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
ğ	quire n sig uld b	D D	CHRONIC C	ongestw	r Nton	1 toul	ui		1	Yes 2	No 3□ Pro	bably 4 □Unknown
000	aw re s bee	lete	Gout.	U					24a. Wa	s an	24b. Were aut	opsy findings available
æ	The lav	E							_ per	opsy formed?	death?	ompletion of cause of
or Vital Records,	10 1-7		25. Was case referred to medic	al				26 Place o	1 Yes of Death (Check only		1 □Yes	2 No
>	Physician: this certific ral director,	o Be	examiner? 1 ☐ Yes 💥 No	Hoepital:	Inpatient 2	1 EB/Outpatie	nt 3 DOA	lthor:	ing Home 5		6 □Other (Spec	(f ₁)
ō	g Phy er thi	. To	27. Manner of eath	28a. Dat	e of Injury	28b. Time o			28d. Describe			197
o	Attending F r death. ector: After by the funera	흪	1 Natural 5 Pend 2 Accident invest	ing (MC tigation	onth, Day Year)	Injury		□Yes 2□No	o			
Division	Atte r dea ecto	Lice	3 ☐ Suicide 6 ☐ Could	minod 20t. Flat	ce of injury - At h	ome, farm, st	reet, factory, offic	е	28f. Location	(Street an	nd Number or Rui	al Route Number,
	al or s afte	Certification:	4 [] Hornicide	Duli	ding, etc. (Speci	119)			City of T	own, state	=)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 12 Certify	ing Physician: To the	ne best of my kn	owledge, dea	th occurred at the	time, date and	place, and due to th	e cause(s) and manner as	stated.
	n 24 n 24 ne Fu	Medical	(Check only 2 ☐ Medica	I Examiner: On the and ma	basis of examin inner stated.	ation and/or it	ivestigation, in m	y opinion, death	occurred at the time	e, date an	d place, and due	to the cause(s)
	To the I within 2. To the I complet	M	29b. Signature and title of certifi	ér)			29c. Lice	nse number	-	_	te signed (Month	
	L.		1 May E	vuen /	()		10	1702	/	A	mil 16,	2007
1	7		30. Name and address of perso	n who completed ca	use of death (Ite	m 23a) (Type,	Print)	/		/	·	
'	10		John W. Roache		,	,		, Mecha	nicsville	, Mai	ryland	20659
	Sta	ite	31. Date filed (Month, Day, Yea.	r) 32.	Registrar's Sign	ature				,		
П	Registr	rar	APR 1	7 2007		M A	hacks					

07-02959	
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Suzanne Henning Linley

Please

Type or Print in Black Indelible Ink. Ensure All Copies Are Le	egible.	
State of Maryland / Department of Health and Mental Hygiene	2087	1350
Contificate of Dooth	Pos No	

		- For State Registrar		Certificate of Death Reg. No.													
Physicia	_	Decedent's Name	(First, Midd	le,Last)									. Date of De Month		y Year	3.	Time of Death
edम्चा Examii					Suzann	e Li	n1ey		_				Month April 17,	2007			2114 hrs
		4a. Facility Name (if I		_	street and nu	imber)		4	b. City, Tow Leonard		ocation of				4c. County of D St. Mary's		
Funeral		5. Social Security Nu	ımber	6. Sex		7. Age (Ir	n yrs. last bir	rthday)	If Under		If Under		8. Date of E	Birth (N	M/DD/YYYY) 9	. Birthp	lace (State or
Director		283-36-47	727		м 2 🗓 F		67	Yrs.	Months	Days	Hours	Min.	Februa	ry 1	7,1940	Count	try) Ohio
	-	Usual Residence of I			VI 2 11	L	07										
à à	ŀ		0b. County			10	c. City, Towr	n or Locati	on							10	0d. Inside City Limits
2 4 2		M- 11	C.L	Max	1-		T c	oonar	dtown							1	1 Yes 2 X No
/land -f sh	호	Maryland 10e. Street and Num	St.	Mai	y S			onar	10f. Zip C	ode			_	10g. I	Citizen of What	Country	y?
Mary r 28a	Director														USA		
h the		40766 Cer	nter 4	40 C				140.00		0650		-2 / 500	oifu Von or	No		merica	n Indian, Black,
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral	Marital Status Never Married	d 2 🗆	Aprilod	12. Was De Armed F	orces?			es, specify				cify Yes or I Rican, etc.)	40-	White, e		Third and the second
deat or ite	5				1 Yes	2 X	No			٦	. "				Specify: W	lhit	
	<u>a</u>	3 Widowed			If Yes, Give Ye or Dates:				Yes 2X			ind of	ark dono	16	b. Kind of Busin		
natur X.m	8	15. Decedent's Edu						. Deceden during m	t's Usual Oost of worki	ccupation ng life. I	DO NOT u	use retire	ed)	1,0	D. Rand of Dusin	.033/1110	dony
6 1721 au ", last	Completed	Elementary/Secon	ndary (0-12)		1-4 or 5+)		T	- - -					1	oublic H	li ah	School
withii iene.	Ĕ	12		1 2 2 3 3		+		1	eache		8 Mother's	s Name i	First, Middle		den Surname)	11.511	Benoor
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", cevent, the Midical Examiner.	ပို	17. Father's Name (I			Ionnin					1			•		/illiams	3	
d be fental arke	ă	19a. Informant's Nar				5	1	9b. Mailine	Address	(Street					r, City or Town,		Zip Code)
	F	Lisa L. Br				-	1.0								Maryland		
and 2 ealth em 2		20a. Method of Disp					20b. Place	of Dispos	sition (Name			<u> </u>	Date		0c. Location - C		
Ore of H		1 Burial 2		on 3	Removal	from State	Motron	atory or ot	herplace) n C rem a	atory	.	Apri	1 20.20	707	Alexandr	ia.	Virginia
Pag ment tant:		4 Donation 5	Other :	Specify:	-		Tietrop										
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumatingry or other traumatingry.	1	21. Signature of Fur	neral Servic	e Licen	\$60 /	1.	1	22. r	Name and A	aaress 37 27		Matt.	ingley-	Gard	liner Fund Land 2065	eral	Home, P.A.
- 1		23a. Fart I. Enter the	19	1	fard	ME!	o death Do										Approximate Interval
Physician ledical		failure. List only	y one caus	e on ea	ch line.					ayg,		_	,				Between Onset and Death
.aminer		Immediate Cause (For condition resulting			Atheroscle			cular Dis	ease	_				_		-	
		or condition resultin	ig in death)	h	Due to (or as	a consequ	derice or).										1
	ē	Sequentially list cor if any, leading to im		ь.	Due to (or as	a consequ	uence of):										
	ii.	cause. Enter Under (Disease or injury th		C.												-	
od Isit	Examiner	events resulting in o			Due to (or as	a conseq	uence ot):										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		UNPENDED		_ը	AMENDED	<u> </u>										-	
50, te be ex ysician burial	Physician/Medical						of pregnance	CV			-				23d. Date of de	elivery	7
8760, ifficate be ng physic is the bur	Z	IF FEMALE: 23b. Was decedent		the	1 Live		or pregnant	2 F	etal death	3	Ectopic	c pregna	ncy		Month	Da	ay Year
Box 68's death certification attending	icia	past 12 months				gnant at tir	me of death		ther (Spec								
Bo e deat the at ed for	hys	1 Yes 2 🗸 N		Inknown	90116	nown						-41	220 D	id tob	oco use contrib	ute to ti	he cause of death?
.O. hat th ed by letach	by P	Part II. Other signi	ficant cond	ditions	contributing	to death t	but not result	ting in the	underlying	cause g	iven in Pa	art I.					ably 4 Unknown
s, P.C iires that signed													24a. W				opsy findings available
ords v requ s beer shoul	et												а	utopsy erform	pri	ior to co	ompletion of cause of
ecc he lar ate ha	Completed													es 2		✓ Yes	s 2 No
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should !	BeC	25. Was case refer	red to medi						2		of Death	(Check	only one)				
Vita ysicia his ce direc	10 B	examiner? 1 ✓ Yes	2 No	['	Hospital: 1	Inpatien	t 2 ER	l/Outpatier			Other ₄		g Home 5		esidence 6 🗸		Scene
of ing Ph After t	=	27. Manner of Deat	th		28a. Da (Mo	te of Injury		b. Time of	Injury 2		ry at Worl	.	28d. Descr	ibe ho	w injury occurre	d	
On rendia sath. or: /	[글	1 V Natural		ending vestigat	ion						Yes 2						
Division tal or Attendit rs after death.	≝	2 Accident 3 Suicide	r	ould not	28e Pl	ace of Inju	ıry - At home	e, farm, str	eet, factory,	office t	ouilding, e	tc.	28f. Locati or Tov			r or Rur	ral Route Number, City
Divipital cours at filled	Certification:	4 Homicide		termine	10,000												
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1	Certifying	Physic	ian: To the b	est of my	knowledge,	death occ	urred at the	time, da	ate and pl	ace, and	due to the	cause	s) and manner a	as state	ed.
Fo the Hos within 24 h To the Fur completely	Medical	2 🗸	Medical E	xamine	r:On the bas and manne		ination and/	or investig					at the time, t		nd place, and du		
	ž	29b. Signature and	title of cert	ifier	(1			290		e number				29d. Date signe		ith, Day, Year)
	/	1 0 as	Vir	la.	MI)				O.C.	M.E.				April 18, 20	07	
	(30. Name and addr	ress of pers					a)									
		Laron Lock			stant Medi	cal Exa	miner ´	111 Per	n Street,	Baltii	more, N	/ID 212	201				
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State

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31. Date filed (Month, Day, Year)

APR 1 1 2007

32. Re strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 23 2007 APRIL **Physician** 11:07 PM CLARA GENEVE McGUIGAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | DEC . 26 , 1912 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 √2 F 94 Yrs. MD. 579-09-6716 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 28a-f show Yes 2 No LA PLATA MARYLAND CHARLES Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **#1 MAGNOLIA DRIVE** 20646 U.S.A. Items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on the and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐No Maryland 21215-0036 Specify: Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES A. JAMESON CATHERINE E. GRAY ဂ injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7011 EVERGREEN DR. WALDORF, MD. 20601 MICHAEL McGUIGAN-SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) METROPOLITAN CREMATORY 4-24-07 ALEX., VA. 21. Signature of Funeral Service Licensee MOO479 2. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CONSESTIVE Due to (or as 10 nsequence of): Immediate Cause (Final disease or condition resulting in death) Physician MONTO /Medicai FIBRILLATION ATRIAL Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of) attending physician for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown INSUFFICENCE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? or Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D- 44436 24 2007 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) ASHVIN PATEL 102 PAUL MELLON COURT SUITE 102 WALDORF, MD 20602-2793 31. Date filed (Month, Day, Year) State APR 2 6 2007 Registrar

DHMH 17 Rev 1/2001

Physician /Medical Examiner attending physician and for use es the burial-transit Hospital or Attending Physician: The law requires thet the daath certificate be executed Division of Vital Records, P.O. Box 68760, ed by the a this Diractor: After the death. within 24 hours after de To the Funeret Diracto completely filled in by th To the

Physician

/Medical

Examiner

10a State

Funeral

Director

il Hygiane. I other than "natural", or iteme 23a or 28a-f ehow vent, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 Is marked oth any injury or other traumatic event <u>QNC8</u>.

Baltimore, Maryland 21215-0036

Completed by Funeral Director

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Examiner

Completed by Physician/Medical

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Medical Certification:

that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b, Signature and title of certifier

12

31. Date filed (Month, Day, Year) State APR 2 6 2007 Registrar

37 Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew O. Donelson, M.D., 65-C Thomas Johnson Drive, Frederick, MD 21702

D21936

April 20, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 3:10 P Johnson Machael April 14, 2007 Anna /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Nursing Center St. Mary's Leonardtown If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Months **Funeral** Days 1 ☐ M 2 🛣 F 479-14-3118 90 01/25/1917 Director Iowa Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Exercition 2000. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Director Maryland | St. Mary's Leonardtown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20650 United States 22680 Cedar Lane Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates: Specify. 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Andrew P. Johnson Laura Heath 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 Karenwald Lane, Schenectady, NY 12309 James R. Edgar, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Episcopal Cem 04/18/2007 St. Mary's City, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Funeral Service Licen 21. Signati Brinsfield, Jr. Edward N. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as o rdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final au **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a ence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 □Ectopic pregnancy for Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2 No detached the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed? 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation s after death.

I Director: A

d in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined within 24 hours a To the Funeral I Hospital 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel

State Registrar

29b. Signature and title of

James P.

30. Name and addres of person who cor

31. Date filed (Month Day, Year)

certifier

Jarboe,

APR 1 7 2007

M.D

24035 Three Notch Road, Hollywood, Maryland

cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29d. Date signed (Month, Day, Year)

20636

State of Maryland / Department of Health and Mental Hygiene | | | | For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2007 4:05 pM April 12, Robert Pau1 Meinecke /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall tf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 ☐ F 09/09/1935 New York Director 053-28-4151 Usuat Residence of Decedent daath with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r then "neturel", or items 23s or 28e-f ehow tre Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland | St. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Road 20622 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours aftar Hygiana. 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Š Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates Whi<u>te</u> Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Air Force Logistician 12 ie marked other Injury or other traumatic event, permit. Pagas 1 and 2 should be file Dapartment of Health and Mantal Hy Important: if Item 27 ie marked other my injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paula Weber Robert Paul Meinecke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paul G. Meinecke/Brother 46564 Yorktown Road, Lexington Park, MD 20653 20b. Place of Disposition (Name of cometery, crematory or other place)
Arlington
National Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/02/2007 Arlington, Virginia 21. Signature of Fyneral Service Licenses 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward No Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician End Stage Chronic Obstructive Pulmonary Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to lor as a consequence of: Examiner the Hospital or Attending Physician: The law requiras that tha death certificate be executed for usa as tha burial-transi attanding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2CXNo 1 Yes 2□ No 1 Yes ours aftar daath. heral Director: Aftar this cartific fillad in by tha funaral diractor, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 🏖 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral E 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0056752 2holm N 04/12/2007 30. Name and ad e s of person who completed cause of death (Item 23a) (Type, Print) Naznin Esphani, MD. 29449 Charlotte Hall Rd, Charlotte Hall, Maryland 20622 31. Date filed (Month, Day, Year) 32. gistrar's Signatur State Registrar 2007

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DHMH 17 Rev 1/2001

Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Late.		Necedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yeer	3. Time of D	
	Physicia /Medic Examin	ai -	James Atlee Melv	reet and number)		4b. Cily, Town, or	Location of De	April 19	4c. County of Death		Рм
	Funeral		Charlotte Hall V 5. Social Security Number 229-28-1755 6. Sex	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		9. Birti	nplace (State or i	Foreign d
	Director Mode		Usuat Residence of Decedent 10a. State Maryland Tob. County ST. Mar	10c. City,	Town or Lo	cation te Hall				10d. Inside City	
	with the N a or 28a-		100. Street and Number 29449 Charlotte	Hall Rd.		10f. Zip Code 20622	2	104	g. Citizen of What Co USA	untry?	
250	tied within 72 hours after deeth with the Maryland Hygiene. Hygiene sthan "natural", or Itama 23a or 28a-f ahow sthar than "natural", or Itaminar must be notified at ent, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Moroced	2. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If ¥es, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit Specify:		
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7	led will lygien har th		17. Father's Name (First, Middle, Last)	4	Cast	mer serv.		Name (First, Middle, M			
	should be filed withir nd Mental Hygiene. marked other then matic event, the M	To Be	George H. Melvill	e			Dorot	hy Freeman			
Mary			19a. Informant's Name/Relationship (Type John Melville/Son		5251	Meadowbro	ook Dr.	, Mechanic	sburg, PA	17050	
more,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 Is any injury or other tra <u>once.</u>		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State Bri	ace of Dispo emetery, cre nsfie.	osition (Name of matory or other place Ld-Echols	Crem.	April 20,	Oc. Location - City or Charlotte		D
Baltimor	permit. Departm Importa any inju		21. Signature of Funeral Service Licenses	the	30	0195 Three	e Notch	Brinsfield- n Rd., Char diac or respiratory arre	lotte Hall		622
	Physician /Medical Examiner	er	shock, or heart failure. List only or Immediate Cause (Finat disease or condition resulting in death)	bue to (or as a consequence to form the form to form	1C (ALCINO,		Onset and D	eath
8/60,	ate be executed hysicien and the buriat-transit	ai Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
O. Box 68	he death certificate the attending physicate thed for use as the l	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of di	I death 3	□Ectopic pregnanc: □ Other (specify) _	у		23d. Date of de Month		ear ear
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Recor	hysician: The law requ his certificete hes been I director, page 2 shout	Completed	-11/11/11/10					24a. Was a autops perform	y prior to death?	utopsy findings a completion of ca s 2 No	available ause of
ta	ian: T	Be C	25. Was case reterred to medical examiner?					Death (Check only on	θ)	ASSIS	CTEL
Division of Vital Records,	Attanding Physician: The law requires thet the rideath. ector: After this certificate hes been signed by the ty the funeral director, page 2 should be delached.	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpation 28b. Time Injury	of 28c. inju			once 6 Other (Sp ow injury occurred	ecity)	NG
Divisi	를 다 들	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, s	street, factory, office		28f. Location (St City or Town	reet and Number or I n, State)	Rural Route Num	ber,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my known on the basis of examinating and manner stated.	owledge, deation and/or	ath occurred at the tinvestigation, in my	ime, date and opinion, death	occurred at the time, d	ate and place, and di	18 to the cause(s	;)
)	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licen	ise number)6	9d. Date signed (Mo	nth, Day, Year))
			30. Name and address of person who of Dr. Louis Kaufman				ite 20	7, Waldorf,	MD 20602	, ,	
F	Regis		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature						
DI	HMH 17 Rev 1/	2001		7	ODI	210103					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Hortense Zeltner Paster 6:45 P April 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North Bethesda Montgomery Brighton Gardens If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Funeral 1 □ M 2 X F 3, 1921 New York 088-20-5360 85 Aug. **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No North Bethesda Maryland Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 United States 5500 Tuckerman Lane Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No specify: White þ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Zeltner Mollie Metzger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4935 Linnean Ave. NW Washington, DC 20008 Howard G. Paster / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Falls Church, Virginia 4-12-2007 National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature // uneral Service Licen 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Respiratory Failure /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 X No ed by the 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed the should be determined by 23e. Did tobacco use contribute to the cause of death? þ Type I Diabetes Mellitus 1 Tes 2 No 3 Probably 4 Unknown Completed Supraventricular Tachycardia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No page 2 2 No certificate 1 ☐ Yes 1□ Yes director, Assisted Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: 24 hours after death.

Funeral Director: After it etely filled in by the funeral To the Hos within 24 ho To the Fun completely 1

> State Registrar

Medical

29a. Certifier

Gary E.

29b. Signature and title of certifier

Cedar Lane #202A / Bethesda, MD 20814 Raffel. 5411 W. D.O. 31. Date filed (Month, Day, Year) APR 1 2 32 Registrar's Signature 2007

and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

H45839

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Billie Smathers Parks 7:55 A. M 10, 2007 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Brighton Gardens Assisted Living Columbia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 M 2 F Director 88 April 7,1919 New Jersey 579-62-6844 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Maryland Howard Columbia 1 1√1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21045 7110 Minstrel Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify: White <u>Ş</u> 3 ₩ Widowed 4 Divorced Completed or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev is marked Cybil Brady William Smathers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9272 Lapwing Ct., Columbia, MD 21045 Lisa Mason/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Georgetown University April Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 Donation 5 ☐ Other (Specify) 2007 Center Medical Signature of Funefal Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, Inc. MO969 Such P.O. Box 58007 Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Seven days preu monia Bacterial Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending I for use as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ accident Cerebral Vascular 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen cancer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has certificate 1□ Yes 25. Was case referred to medical examiner? ASSISTED 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical d manner stated. 29b. Signature and title of certifier M.D. 56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pkwy, suite 301, columbia, mD21045 8600 Snowden River Li 32. Register's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** Day 14 11:55 P M Charles Cleaveland Rush, Jr. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 20826 Waterside Drive Leonardtown St. Mary's 8. Date of Birth (Month, Day, Year June 25, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1**₺**М 2□F Months Days Hours 229-14-7401 85 Director Ĩ921 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int. If Item 27 Is marked other than "natural", or items 23a or 28a-f show r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland St. Mary's 1 ☐ Yes 21 No Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 1 20826 Waterside Drive 20650 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No White Completed by 3K Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) US Government Elementary/Secondary (0-12) College (1-4or 5+) Aerospace Engineer Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Cleaveland Rush, Sr. Flossie Bell Grant ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dr. Susan Elaine Rush / Daughter 20820 Waterside Drive, Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If its any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April 18 Mt. Olivet Cemetery McGaheysville, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 Tarouner 23a. Part I. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such that or diagon respirat the arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner 0110 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner a consequence or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery sate has been signed by the atte page 2 should be detached for 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 1∐ Yes 2 No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 P No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA s after de...
ral Director: Afte,
rul the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 🔳 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier 1 🙋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D06419

State Registrar

31. Date filed (Month, Day, Year)
APR 1 6 2007

24035 Three Notch Road

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James P. Jarboe, M.D.

Hollywood, MD 20636

P.O. Box 68760, Division or Vital Records,

law requires that the death certificate be executed ours after death.
neral Director: / Hospital or 24 hours a within 2 To the I

with

3altimore, Maryland 21215-0036

Pages 1 and 2

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a, Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D0060210 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amish Shah, MD 24635 Three 24035 Three Notch Road, Hollywood, MD 20636

State Registrar 31. Date filed (Month, Day, Year)
APR 1 6 2007



Division or Vital Records, P.O. Box 68760,

Fo the Hospital or Attending Physician: ח 24 hours. •he Funeral ה within 24 ho

To the Function

State Registrar

29b. Signature and title of certifie

Rajbinder Gill, M.D. Shah Associates, Hollywood, Maryland 20636 31. Date filed (Month, Day, Year) 32. Reg

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 56096

29d. Date signed (Month, Day, Year)

07-02580 Louise Jacqueli	ne S	1- For State Certificate of Death	Hygiene	2007 135
Physic	an/	Registrar	2. Date of Death	o. I mio oi Boulii
Medical Exam	iner	Louise Sacqueline Santos	April 4, 200	Day Year 1835 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat 22426 Cornwall Drive California	th	4c. County of Death St. Mary's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	rs. 8. Date of Birth	h(MM/DD/YYYY) 9. Birthplace (State or
Director		151-52-1817 1 M 2 X F 51 Yrs. Months Days Hours Mi		Foreign
any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Lim
and F show	ō	Maryland St. Mary's California		1 Yes 2 X
Maryl r 28a-	Funeral Director	10e. Street and Number 10f. Zip Code	10	g Citizen of What Country?
ith the	al Di	22426 Cornwall Drive 20619		nited States
ath wi	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Some of the state o		 Race - American Indian, Black, White, etc.
fter de				Specify: White
ours a: atura xamin	d by			16b. Kind of Business/Industry
36 n 72 h nan "n ical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ured)	
5-0036 iled within 7 Hygiene. I other than the Medica	omo	12 Grocer 17. Father's Name (First, Middle, Last) 18.Mother's Nam	ne (First, Middle, M	Grocery Store
215. re filec tal Hy ked of	Be		lathaway	and the damanie
2121 ould be fil d Mental E s marked itc event,	2			ber, City or Town, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I (tiem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		Carlos L. Santos/Husband 22426 Cornwall Drive	, Califor	rnia, Maryland 20619
of Hez		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Arlington 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify: LNational Cemetery 105/	08/2007	Arlington, Virginia
Bal permit Depar Impo				Funeral Home, P.A.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	oad, Leor or respiratory arres	
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Acute alcohol intoxication		Between Onset an Death
Examiner		or condition resulting in death) Due to (or as a consequence of):		
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	xaminer	cause. Enter Underlying Cause (Disease or injury that initiated	_	344
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executed an and al - transi	cal	MUNPENDED AMENDER 20 6 ME 000 /07 PHP		
D.O. Box 68760, that the death certificate be exectly the attending physician detached for use as the burial.	Physician/Medical E	##SINCET, 28a-f, perME, g866, 4/30/07 TT IF FEMALE: 123c. If yes, outcome of pregnancy		23d. Date of delivery
Box 68760 re death certificate by the attending physined for use as the bu	an/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregr	nancy	Month Day Year
eath c atten for us	sici	1 Yes 2 No 9 ✓ Unknown		
D. B t the d by the			23e. Did tob	pacco use contribute to the cause of death?
P.C. res that signed be det	d by		1 Yes	2 No 3 Probably 4 Unknown
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eco he law ite has	m d		perform 1 ✓ Yes 2	ned? death?
an: T ertifica tor, pa	ပ	25. Was case referred to medical 26.Place of Death (Check		
Vita hysici this co	0 B	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA Nursi	ing Home 5 F	Residence 6 🗸 Other: Scene
n of Vital Records, P.C ding Physician: The law requires that After this certificate has been signed funeral director, page 2 should be dete	n: T	20a. Date of injury 20b. Time of injury 20c. Injury at work?	28d. Describe ho	ow injury occurred
Sior Vttend death. sctor:	catic	Pending Fnd 4/4/2007 Fnd 6:24 pm 1 Yes 2X No	unknown	troot and Number or Purel Parts Number C
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the and redeath. The are cleath. The record of the certificate has been signed by led in by the funeral director, page 2 should be detact	Certification	3 Suicide 6 X Could not be determined determined (specify) found: residence	or Town St	treet and Number or Rural Route Number, Cl ate) Nwall Dr. California, MD
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Furnaria Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri				
thin 2-	/ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated/		
F 3 E 8	Je	29h Signature and title of oertifier 29c License number	T	29d Date signed (Month Day Year)

State 31. Dat A DK Menth Day Year) Registrar 2007

29b. Signature and title of certifi

Susan Hogan MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 5, 2007

			1 _ State	State of Maryland		artment of F		nd Mental H		atro atto atto them.	10501
e.		10	Registrar 1. Decedent's Name (First, Middle, Last)		001	Timoato or		2. Date of D	Reg. No.	2007	3. Time of Death
П	Physici		Amado Punzaran San	galan				Month April	10 Day	Year 2007	1:00pm [™]
	/Medio		4a. Facility Name (If not institution, give str	-		4b. City, Town, o	r Location of I			County of Death	1:00pm
	Sec.		18 West Deer Park B	Road #304		Gaither	sburg		M	lontgomer	·v
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days		Min. (Month, L	irth Jay, Year)	9. Birthp Coun	lace (State or Foreign try)
Xe.	Director		Usual Residence of Decedent	78	Yrs.			Nov. 8	3, 19	28 Phil:	ippines
	land ow		10a. State 10b. County	10c. City,	Town or Lo	ocation				1	0d. Inside City Limits
	Mary a-f sh fied	ţċ	 Maryland Montgomery	Ga:	ithers	sburg					1 X Yes 2 □ No
	th the or 28;	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Coun	try?
	ath wi	<u>a</u>	18 West Deer Park F	Road #304		20877				ed State	
	tems	Funeral	11. Maria Status	Was Decedent Ever in U.S Armed Forces?	13.	Was Decedent of H If Yes, specify Cuba	lispanic Origii an, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	0-	 Race - Americ Black, White, 	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:			Specify: Fil	ipino
ş	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ed	15. Decedent's Educa	tion	16a. Dece	dent's Usual Occup	ation		16b. Ki	nd of Business/Inc	lustry
212	hin 73 an "n Medi	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give life.	kind of work done DO NOT use retired	during most o d)	of working			
7	filed wit Hygien other tha	S	12	, , , , , , , , , , , , , , , , , , , ,	X-Ray	Technic				pital	
D D	be file	Be	17. Father's Name (First, Middle, Last)			ļ		s Name (First, Middi	•	Surname)	
<u> </u>	2 should to and Menton Is marked raumatic e	2	Pablo Sangalan 19a. Informant's Name/Relationship (Type	Print)	10h Maili	Address (Ctt		idad Punz		.T 0.4 T	2 ()
<u>a</u>	es 1 and 2 should be fi of Health and Mental F I ttem 27 Is marked ot r other traumatic ever		Abner M. Sangalan	(Son)				or Rural Route Num			
ē,	s 1 and f Health tem 27 other tr		20a. Method of Disposition		L	sition (Name of matory or other place		Date Date	_	cation - City or To	
Baltimore, Maryland 2121ನ-0036	Pages nent of h ant: If Ite ary or o		1X Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	novai irom state		Cemeter	t t	/13/07	Corm	nantwon,	Maruland
<u>a</u>	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service License		2:	Name and Addre	ss of Facility	DeVol Fun	eral	Home	Maryrand
מ	P E E E	N 1	West X-W	101	Ga) East De ithersbu	er Par rg, MD	20877			
			23a. Parti. Enter the disease, or complica shock, or heart failure. List only one	ations that caused the death. cause on each line.	Do not ent	er the mode of dyir	ng, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Carcinoma of	Liver	•					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):						
		je e	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):					-	
	uted d ansit	Examiner	Cause (Disease or injury	,							
oʻ	exec an and rial-tra	Exa	resulting in death) Last	Due to (or as a conseque	ence of):						
8/60,	cate be executed ohysician and the burial-transit	dical	d.								
٥	death certificate be executed e attending physician and d for use as the burial-transit	Med	IF FEMALE:								
X P P	leath certific attending p for use as	ian/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome pf pregnan 1 ☐ Live birth 2 ☐ Fetal (death 3[Ectopic pregnancy	/		2	23d. Date of delive Month	ry Day Year
- -	he de the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at time of dea 9⊡Unknown	ath 5L	Other (specify)					, , , , , , , , , , , , , , , , , , ,
Į.	w requires that the d been signed by the should be detached		Part II. Other significant conditions contr	ibuting to death but not result	ting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to th	e cause of death?
ds,	quires n sign lld be	d by	Hepatic Encepalopat	hy				1] Yes 2[]No 3 ☐ Prob	ably 4 K∐Unknown
Vital Record	law rec as beel 2 shou	Completed						24a. Wa	s an	24b. Were auto	osy findings available
ř	The lay ite has vage 2	ош						per	opsy formed?	prior to cor death?	npletion of cause of
g		ø	25. Was case referred to medical				26. Place o	1 Yes of Death (Check only		1 □ Yes	2⊠No
_	S S	To B	examiner? 1 ☐ Yes 2X No	spital: 1 □ Inpatient 2 □ E	R/Outpatier	nt 3□ DOA Oth	er: 4 🗆 Nurs	sing Home 5X Res	sidence (6 □Other (Specify	<i>'</i>)
0	ng ffer ine		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe	how injur	y occurred	
<u> </u>	Attending r death. ector; After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be	20. Bl			Yes 2 □ No				
UIVISION	l or Ai after c Direc	Certification:	4 Homicide determined	28e. Place of injury - At hon building, etc. (Specify)	ne, rarm, str	еет, тастогу, опісе			(Street an own, State	d Number or Rura)	l Route Number,
	spita nours neral / filled		29a. Certifier 1 X Certifying Physic	cian: To the best of my know	ledge, deat	h occurred at the tir	ne, date and	place, and due to th	e cause(s)	and manner as st	ated.
	• To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Examine one)	er: On the basis of examination and manner stated.	on and/or in	vestigation, in my o	pinion, death	occurred at the time	e, date and	d place, and due to	the cause(s)
	with Tot	M	29b. Signature and title of certifier	P amas		29c. Licens	e number		29d. Dat	e signed (Month,	Day, Year)
ì	7		Manen HX	ucus my			00555	22	Apri	1 11, 20	07
	:		30. Name and address of person who com Robert H. Gerard, M.			•	Silver	Spring.	MD 20	910	

State Registrar 31. Date filed (Month, Day, Year)

APR 1 2 2007



			1 - State of Management of Registrar	aryland / Depa <i>Cer</i>	rtificate of D		, ,	iene _{eg. No.} 2 (07	13522
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Stansbury E. Shockley				2. Date of Deat Month	h Day	Year	3. Time of Death
)	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) Castel Hospice A+ The Lake	e (In yrs. last birthday) 78 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp Coun	Dolace (State or Foreign
	with the Maryland a or 28a-f show be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Worcester	10c. City, Town or Loc Berlin	cation				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23a or 28a-f show r must be notified at	eral Director	10e. Street and Number 137 Flower Street 11 Marital Status 12. Was Decedent	Ever in U.S. 12.1	10f. Zip Code 218			0g. Citizen of	What Coun USA ce - Americ	
2-0036	ours after de ral", or item Examiner r	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Armed Forces? 1 ☑ Yes 2 □ If Yes, Give Year or Dates:	No Army	Vas Decedent of Hisp f Yes, specify Cuban I ☐ Yes 2 <mark>12</mark> No	, Mexican, Puerto F	Rican, etc.)	Bla	ck, White, fy:Blac	etc.
0-CIZI:	be filed within 72 hours after death w Ital Hygian "natural", or items 23a of other than "natural", or items 23a event, the Medical Examiner must t	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	lent's Usual Occupat kind of work done du DO NOT use retired) Painte:	iring most of workir	ng	16b. Kind of E		dustry ployed
/land /	should be filed ind Mental Hygis marked other umatic event, ti	To Be Co	17. Father's Name (First, Middle, Last) Carl Shockley			18. Mother's Name Dollie S				picyca
e, Mar	s 1 and 2 sho of Health and item 27 is ma other trauma		19a. Informant's Name/Relationship (Type. Print) Stansbury E. Shockley, Jr./ 20a. Method of Disposition	Son 137 F	lower St.	, Berlin,	MD 218	-	•	
baltimor	t. Page rtment c rtant: If rjury or		20a. Method of Disposition 1	St. Paul'	sition (Name of natory or other place) S Cemeters Name and Address	y 4/11/		erlin,	-	wn, state
ם מ	permi Depar Impor any ir		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	L	ewis N. Wa 618 West I	atson Fur Road, Sal	isbury.	MD 21	801	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition	a consequence of):	chareol	Cancel				Onset and Death
,00	ificate be executed g physician and as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence of):						
O. Box 68/60,	The law requires that the death certificate b the has been signed by the attending physic age 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\triangle \text{ Yes} \) 2 \(\triangle \text{ No} \) 9 \(\triangle \triangle \text{ Unknown} \) d. 23c. If yes, outcome 1 \(\triangle \triangle \text{ Live birth} \) 4 \(\triangle \text{ Pregnant a} \) 9 \(\triangle \triang	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)				ate of deliver	ery Day Year
cords, F.	equires that ten signed by ould be detac	þ	Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause given	n in Part I.	23e. Did tot	1	tribute to th	he cause of death? pably 4 □Unknown
al Reco	i; The law re icate has be i; page 2 sho	Completed					24a. Was a autops perform 1 Yes	sy	Were auto prior to co death? 1 Yes	ppsy findings available mpletion of cause of 22 No
or vital	Physiciar er this certif eral director	: To Be	25. Was case referred to medical examiner? 1 □ Yes 257No 27. Manner of Death Respital: 157Inpatie 28a. Date of Inju	iry 28b. Time of	t 3 DOA Other	4 Li Nursing noi		ence 6 🗆 Ot		ý)
JIVISION	To the Hospital or Attending Physician: The law within 24 butus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	1 ★ Natural 5 Pending (Month, Da 2 Accident investigation 3 Suicide 4 Homicide	y Year) Injury ury - At home, farm, street. (Specify)	M 1 □ Ye	es 2□No	28f. Location (St City or Town	reet and Num n, State)	ber or Rura	al Route Number,
_	he Hospital In 24 hours a he Funeral pletely filled	Medical Co	29a. Certifier (Check only one) Check only Medical Examiner: On the basis of and manner st	f examination and/or in	n occurred at the time vestigation, in my opi	e, date and place, a inion, death occurr	and due to the c ed at the time, d	ause(s) and n late and place	nanner as s , and due t	tated. o the cause(s)
	To T with	Σ	29b. Signature and title of certifier	nD	29c. License	14279	8	9d. Date sign	1-0	7
	IM		30. Name and address of person who completed cause of completed cause of a second of the completed cause of the completed c	1 / //	Print)	Bux 1733	3 Sal	lish	Mis :	71802
	Sta Registr		APR 1 2 2007	us H So	make			A		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** CHARLOTTE ISABEL. STARLING TIGHE APRIL 14 2007 4:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months Hours 1 □ M 2 🔽 034-28-1369 97 OCT 14 1909 Director MA Usual Residence of Decedent bould be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or items 23a or 28a-f shov iminer must be notified at 1 ☐ Yes 2 No Director MD FREDERICK ADAMSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3200 BAKER CIRCLE 21710 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE Specify: 3 ₩idowed 4 Divorced 'natural", 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. other than STATE GOVERNMENT SOCIAL WORKER of Health and Mental Hygie I Item 27 is marked other r other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev GEORGE STARLING EVA STROUT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLOTTE HOLDEN/DAUGHTER 17202 LIGHTFOOT LA., POOLESVILLE, MD 20837 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MONOCACY CEMETERY 4/17/2007 BEALLSVILLE, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HILTON FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20838 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician CONGESTIVE HEART FAILURE /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-tra Due to (or as a consequence of): death certificate be Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) the 9 ☐ Unknown signed by det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 Yes 2∏ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification; To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannyr of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) Injury M 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

> State Registrar

3

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

APR 2 6 2007

Wung

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LALIT VERMA, MD 400 W. SEVENTH ST., FREDERICK,

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

D57796

29d. Date signed (Month, Day, Year)

APRIL 20, 2007

21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland	i / Depa <i>Cei</i>	artmen rtificate	t of H	ealth a Death	and M		giene	07	13524
×	*		1. Decedent's Name (First, Middle, La	nst)							2. Date of De	ath		3. Time of Death
	Physic /Medi		I. Jacqueline Ta	mplin							April	_{Бау}	2007	5:45 p ^M
X.	Examir		4a. Facility Name (If not institution, gr	ve street and number)			4b. City,	Town, or	Location o	of Death		4c. Cou	inty of Death	
			Spa Creek Center					nap				A	nne Ai	rundel
	Funeral Director	į.	328-07-5517	Sex 7. Ag	91 (In yrs. la	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da March	th y, Year) 30,191	9. Birthi Could II	place (State or Foreign ntry) Linois
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation							10d. Inside City Limits
	Mary	ច	MD Anne A	rundel		nnapo]								1X Yes 2 □ No
	the 288	Je C	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cour	
	3a or	Funeral Director	24 Baldridge Roa	đ					401			. eg. omzon	USA	
	death me 2	era	11. Marital Status	12. Was Decedent	Ever in U.S	. 13. \	Was Deced			gin? (Spe	ecify Yes or No	- 14. F	Race - Americ	can Indian.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Idher then "naturel", or Iteme 23a or 28a-1 ehow ant, the Medical Evanfrat must be routiled at	by	1 ☐ Never Married 2 ☐ Married 3 🖔 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1	f Yes, spec	rfy Cubai	Specify:	, Puèrto	Rican, etc.)	8	Black, White,	
9	2 ho	Completed	15. Decedent's E			16a. Deced	lent's Usua	l Occupa	ition			16b. Kind of	f Business/In	dustry
215	thin 7	pie	(Specify only highest gr Elementary/Secondary (0-12)		5+)	(Give life. L	kind of wor. DO NOT us	e retired,) -	t of worki	n <i>g</i>			,
2	od wil	Con		College (1-4or s	.,		Home	emake	er				Home	
g	al Hy al Hy I oth	Be (17. Father's Name (First, Middle, Las-	•							(First, Middle,		ame)	
<u>Ja</u>	Ment Ment wrked	To	H. H. Livingston						E	unic	e Nelli	.nger		
Maryland Maryland	und 2 sho alth and I 27 is mu		19a. Informant's Name/Relationship James A. Tamplin				g Address Baldri				Annapol			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other then "naturel", or Iteme 23a or 28a-1 ehow any injury or other traumatic event, the Medical Evantment must be notified at ance.		20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Donation 5 Other (Speci		Ce/	ce of Dispo netery, cren Lro Cr	natory or ot	her place	9)	Αŗ	oril 9,		in - City or To	
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service Lipe			Ba	Name and arrand 95 Go	Addres	s of Facility	y . P.	A. Set	erna I	Park F	uneral Home MD 21146
8760,	Physician /Medical Examiner physician and physician and physician and physician silve private physician silve private physician physicia	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a conseque	ence of):	21601		CAR	.)(0	VASCU	CARL D	1 SEASE	
O. Box 6	The law requires that the death certificat lie has been signed by the attending phy age 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	eath 3	Ectopic pre						Date of delive	ery Day Year
ds, P	ires that signed b	þ	Part II. Dther significant conditions of	contributing to death b	ut not result	ing in the un	derlying ca	use give	n in Part I.					ne cause of death?
0	w requir been s should	etec									101	es 2□No	3 Prob	abiy 4 Unknown
Il Records,		Completed									24a. Was autop perfor 1 Yes	sy	prior to cor death?	psy findings available impletion of cause of 2 No
Vital	ician sertifi ector	Be	25. Was case referred to medical examiner?							of Death	(Check only o	ne)		
<u>o</u>	Physic of this of all directions	ပ္	1 ☐ Yes 2 No	Hospital: 1 Inpatie		R/Outpatient			4 Nur	sing Hon	ne 5 🗌 Resid	ence 6 🗆 C	Other (Specif)	v)
<u></u>	of share	0	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injui	ry y Year) 2	8b. Time of Injury		c. Injury Work	at ?	2	8d. Describe h	ow injury occ	urred	
Sio	tend leath tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not b				М		es 2 🗆 N	10				
Division	To the Hospital or Attending Physician: whith 24 hours after deals after deals To the Funeral Director. After this certifical completely filled in by the funeral director,	Certification:	4 Homicide determined	28e. Place of Injubulding, etc	ury - At hom c. (Specify)	e, farm, stre	et, factory,	office		2	18f. Location (S City or Tow	itreet and Nur n, State)	mber or Rura	l Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exar	ysician: To the best on niner: On the basis of and manner sta	examinatio	n and/or inv	estigation, i	n my opi	nion, deat	h occurre	ed at the time, o	late and place	e, and due to	the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	1 20			29c.	License	number			29d. Date sign	ned (Month,	Day, Year)
)			1 /s. C.	Willer	e un	O		1)	3/12	36		400:1	Co 7	017
		-	30. Nappe and address of person who	completed cause of di	eath (Item 2	3a) (Type F	Print)		-1.0			11/46	17, 1	00/
1000	5 Sta		SRIAN C. (31. Date filed (Month, Day, Year)	NACLACE	oatri (item 2 M) af's Signatur	900	25 1	KIL	BRI	DE	RD,	BAZI	MORE	0ay, Year) 2007 5, Mg 2133
	Registra	-		nn7 Klass	42.4	K 1	asel .	,						

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07-02909		Please Type or Print in Black Indelible Ink. Ensure All Constant of Maryland / Department of Health and Mental	tal Hygien	e e		107 1050
Theresa Mary Vas		For State of Maryland / Department of Floatin and West		Reg. No		007 1352
	R	egistrar . Decedent's Name (First, Middle,Last)		of Death		3. Time of Death
Physician Mei xamine	,	Theresa Mary Vasold	April	16, 2007		1149 hrs
We Admin		a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of	of Death		1c. County of Deat	th
		21 Pine Hurst Berlin			Worcester	interior (Chata an
Funeral	- 5	Social Security Number 6. Sex 7. Age (iii yis: last bit day)	er 24Hrs. 8. Da	te of Birth (MNy 19 ,	1025 Fore	irthplace (State or ign Mary Land
Director		220-11-9845 Annual Price	s Min. Ma	y 19,	1905 C	ountry Tarra
	-	Jsual Residence of Decedent				10d. Inside City Limits
any		10a. State 10b. County 10c. City, Town or Location	,			1 Yes 2 X No
		Maryland Frederick Frederick	`		Citizen of What Co	
arylan at on	읈	10e. Street and Number	2	10g. C	U.S.A	
he M	Director	5674 Farmhouse Drive 21703				
death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	igin? (Specify Y n, Puerto Rican,	es or No- etc.)	White, etc.	erican Indian, Black,
item	Funeral	1 X Never Married 2 Married 1 Yes 2 X No			Specify: \	White
5-0036 led within 72 hours after de Hygiene other than "natural", or the Medival Examiner m	Ş.	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: or Dates: 1 Decedent's Usual Occupation (Give		ne 116	b. Kind of Busines	
ours ? atura xamii		15. Decedent's Education (opens) and ingression of working life, DO NOT	T use retired)			
6 72 h ra "n	<u></u>	Elementary/Secondary (0-12) College (1-4 or 5+) 2 Student			College S	Student
vithin ene er the Medi	Completed		er's Name (First,	Middle, Maid	len Surname)	
Hyging of the		Patrick Edward Vasold	Jeanne	2 Jarv:	is	
121 d be f fental tarke	å	40a Informaci's Name/Relationship (Type Print) 19b. Mailing Address (Street and Nur	umber or Rural R	oute Number	, City or Town, St	ate, Zip Code)
D 2 Shoul and N 7 is m	۵[19a. Informant's Name/Relationship (Type, Print) Jeanne Jarvis Vasold/Mother 19b. Mailing Address (Street and Nor 5674 Farmhouse Dr. 19b. Mailing Address)	rive, Fi	cederro	ck, Mary	Tand 21705
, M and 2 ealth :	ł	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	2000	0c. Location - City	or Town, State
Baltimore, MD 21215-0036 Jermit. Pages I and 2 should be filed within 72 hours after death with the Mary/and Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f shu important: If item 27 is marked other than "hattral for items 23 and 28a-f shu intry or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 XBunal 2 Cremation 3 Removal from State Mt. cremative Certification (Removal from State of Disposition (Removal from State of Disposition).	April 2.	1, 290	/ Frede	rick, Maryland
timent riant		4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee MO0021 22. Name and Address of Facility and Barrier and	lity ford	Funera	1 Home	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thingury or other transmatic event, the Med	İ	21. Significance of Funeral Service Licensee M00021 22. Keeney and Barrier Licensee 106 Fact Chin	irch Str	eet E	rederick	MD 21701
₹ ′sician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	s cardiac or resp	iratory arrest,	shock, or heart	Approximate Interval Between Onset and
edical		tailure. List only one cause on each mile.				Death
⊏xaminer		Immediate Cause (Final disease or condition resulting in death) a. ACUTE ETHANOI INTOXICATION Due to (or as a consequence of):				
		Sequentially list conditions, b				
	ner	if any, leading to immediate Due to (or as a consequence of):			_	
18.	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
executed an and and	ĕ	4	יוויי			
exectian and ital - 1	lical	X unpended X 4#250F,PII,27,28a-f, perME, C868, 6/28/07	<u> </u>			
68760, certificate be nding physici	Ě	IF FEMALE: 23c. If yes, outcome of pregnancy	opic pregnancy		23d. Date of del Month	Day Year
687 ertific ding	ian/		peutic ab	ortion	unknown	
Box e death c the atten	Physician/Medi	1 ✓ Yes 2 No 9 Unknown g Unknown				() 150
ords, P.O. Box 68760, w requires that the death certificate be execute so been signed by the attending physician and should be detached for use as the burial - tran	튑	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I.			re to the cause of death? Probably 4 Unknown
P.O.	à	Retained uterine placenta; oxycodone use				
ds, equire een si	Completed			24a. Was ar autops	y pric	ere autopsy findings available or to completion of cause of
COF law r has b	횰			perform 1 Yes 2		ath? Yes 2 No
Division of Vital Records, ral or Attending Physician: The law requir at Brecords has breed that the certificate has been silled in by the funeral director, page 2 should be			eath (Check only	one)		
ician:	8	examiner? Hospital: 1 Innatient 2 ER/Outpatient 3 DOA Other			Residence 6	
of Vi Physi er this	6		Work? 280	. Describe h	ow injury occurred	
no ading h. : Aft	<u>.</u>	1 Natural 5 Pending 4/16/2007 11:43 am		k		
Sio Atter r deat ector by th	1 5	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building		. Location (S	treet and Number ate)	or Rural Route Number, City
Divi	ertification:	3 Suicide 6 Could not be determined (Specify) found at home			st, Ocean	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate betwithin 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burit	2	29a Certifier . O at the Rhysisian. To the best of my knowledge death occurred at the time, date and	nd place, and due	e to the cause	e(s) and manner a	is stated.
the I the F the F	Modical	29a. Certifiler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	th occurred at the	e time, date a	and place the ter	
To To	Ž					d (Month, Day, Year)
		Det O.C.M.E.			April 17, 200) i
		30. Name and address of person who completed cause of death (Item 23a)	D-16	MD 0400:	1	
1		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street,	t, Baltimore,	עוען 2120'		
	Sta	nmm = 0 =0007 //- (// //				
Regi	stra					
DHMH 17 Rev 1	/200	ORIGINAL				

07-03038

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State of Maryland	Department of He	ealth and Mental F	lvaiene

оѕерп кореп		1- For State Registrar_	Maryland / Departm Certific	ent of Health ar	nd Mental Hy	Reg. No	200	7 13526
Physici Medical Exam		Decedent's Name (First, Middle, Last)				Date of Death Month Day	Year	3. Time of Death 1700 hrs
·	mei	Joseph Robert Weigle 4a. Facility Name (if not institution, give stre		4b. City, Town, o	or Location of Death	April 20, 2007	c. County of Death	
		Frederick Memorial Hospital		Frederick			Frederick	
Funeral Director		5. Social Security Number 6. Sex 578–96–6656 1 X M	7. Age (In yrs. last bit	rthday) If Under 1 Ye Months Da Yrs.		8. Date of Birth(MM 04/12/196	Foreig	thplace (State or in untry) Virginia
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Towr	n or Location				10d. Inside City Limits
	ř	Maryland Frederick	Freder	ick				1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once,	Director	10e. Street and Number	111Cuci.	10f. Zip Code		10g. C	itizen of What Coul	ntry?
h the l	ΙDir	9001 Allington Manor		21703		USA		
5-0036 Ited within 72 hours after death with the Maryland Hygiene other than "natural", or items 23a or 28a-f she the NA dical Examiner must be notified at once	Funeral	1 Never Married 2 X Married 1	Was Decedent Ever in U.S. Armed Forces? Yes 2 X No	13. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	ecify Yes or N o- Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
s after ral",	by	3 Widowed 4 Divorced If Ye or D	ates:	1 Yes 2 X N		140	Specify: Whi	
115-0036 Filed within 72 hours after all Hygiene. Red other than "natural", the M dieal Examiner	Completed	15. Decedent's Education (Specify only high Elementary/Secondary (0-12)	College (1-4 or 5+)	. Decedent's Usual Occupa during most of working life		ed)	. Kind of Business/l	ndustry
036 ithin 7 ne.	nple			oject Manage	r	l _H	ospitalit	.v
15-003(filed within Hygiene. d other tha		17. Father's Name (First, Middle, Last)		J		(First, Middle, Maide		
21215-0036 unld be filed within 7 Mental Hygiene. marked other than ic event, the M diea	Be (Vincent Joseph Weigl	le		Pauline M	ary Hinks		
e, MD 212: 1 and 2 should be Health and Menta item 27 is marke	To	19a. Informant's Name/Relationship (Type,		9b. Mailing Address (Stre				
re, ML s 1 and 2 s if Health at If item 27		Brenda Christine Ake	20b. Place	001 Allingto of Disposition (Name of co	n Manor C emetery,	Date 200	St. Frede Location - City or	Town, State
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		1 Burial 2 X Cremation 3 R 4 Donation 5 Other Specify:	emovar from State	atory or other place)	tory O//	25/2007 6-	nd + b a b	. Many land
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr.		21 Signature of Funeral S	Shire	1sburg Crema: 22. Name and Addres	ss of Facility Kee	nev and B	asford Fr	neral Home
		Kyan M. Dergi	M0099	99 106 East	Church St	reet, Fre	derick, M	D 21701
Physician /Medical		23a. P. I. Enter the disease, or complicate failule. List only one cause on erch in	ne.				hock, or heart	Approximate Interval Between Onset and
raminer			pertensive atheros o (or as a consequence of):	sclerotic cardi	ovascular d	isease		Death
		Sequentially list conditions, b.	o (or as a consequence or).					
	iner	if any, leading to immediate Due to cause. Enter Underlying Gause	o (or as a consequence of):					
103.	Examiner	(Disease or injury that initiated events resulting in death) Last	o (or as a consequence of):					
ecuted and - transit		d						
	ğ	X UNPENDED A	Ž3a,PII,27,perME,g	g867,5/4/07 TT		5.5		
lox 68760, eath certificate be e: attending physiciar for use as the burial	n/M	IF FEMALE: 23 23b. Was decedent pregnant in the 1	c. If yes, outcome of pregnancy	y Petal death 3	Ectopic pregnar		3d. Date of deliver	V Day Year
th cert	icia	past 12 months?	Dramant at time of death	5 Other (Specify)		,	Monar L	July 1 July 1
. Bo he dea y the a	hys	1 Yes 2 No 9 Unknown 9	The state of the s		5- II A	OO Bid Ashan		the control to the
, P.O. ires that the signed by be detach	by	Part II. Other significant conditions cont Chronic alcohol abus		ng in the underlying cause	given in Part I.			the cause of death?
ords, F w requires is been sign should be	Completed	anome arconor abus	<u> </u>			24a. Was an	24b. Were au	topsy findings available
COF e law r e has b	Jd m			 		autopsy performed?	death?	completion of cause of
tal Rec ian: The certificate		25. Was case referred to medical		26 Plan	ce of Death (Check o		No 1 Ye	es 2 No
Vital ysiciau: his certifi director,	o Be	examiner? 1 ✓ Yes 2 No	al: 1 Inpatient 2 🗸 ER/C		Othor		dence 6 Other	:
Division of Vital Records, ral or Attending Physician: The law requirs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should I	-	27. Manner of Death	28a. Date of Injury (Month, Day, Year) 28b.	. Time of Injury 28c. Inj	ury at Work?	28d. Describe how in	njury occurred	
ion ttendi leath.	atio	1 A Natural 5 Pending 2 Accident Investigation	, , , , , , , , , , , , , , , , , , , ,	1	Yes 2 No			
Divis pital or At ours after d feral Direct	ertification:	3 Suicide 6 Could not be	28e. Place of Injury - At home, f	farm, street, factory, office	building, etc.	28f. Location (Street or Town, State)	and Number or Ru	ral Route Number, City
ie e in	ပ	4 Homicide determined 29a. Certifier 1 Continue Physicians I	(Specify)					
DIV To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only one) 2 ✓ Medical Examiner: On t	o the best of my knowledge, de he basis of examination and/or					
To win	Me	29b. Signature and title of certifier	manner stated.	29c. Licen	se number	29d	. Date signed (Mo.	nth, Day, Year)
		Uni	1.1/	O.C	.M.E.	Ap	ril 21, 2007	
d		30. Name and address of person who compl Jack Titus MD. Deputy Chie	, ,	111 Penn Street, Ba	Itimore, MD 21	201		
S	tate	31. Date filed (Month Day Year)		Specific				
Regis	utalī	111 11 10 0 1001	A TOP TO THE PROPERTY OF THE PARTY OF THE PA					

			For State of Maryland / Dep. 1 - State Registrar Ce	rtificate of Death	,	Reg. No. 2 1 1 7	10597
		14	Decedent's Name (First, Middle, Last)	- Indute of Boats	2. Date of Dea		3. Time of Death
Ш	Physicia		Elizabeth Wilson Whetstone		Month April	Day Year 17, 2007	6:17 p ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Whili	4c. County of Deat	0:1/ p
		.úla	St. Mary's Nursing Center	Leonardtown		St. Mary	S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Da	h 9. Birt	hplace (State or Foreign untry)
26.70	Director		249-20-7495 1□M 2☒F 83 Yrs.	Monato Baye House Min.	12/10/		h Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	f sho	JO.					1 ☐ Yes 2 🔯 No
	the 28a-	Director	Maryland Howard Columbia	10f. Zip Code		10g. Citizen of What Co	untry?
	3a or		8582 Black Star Circle	21045		United Stat	•
	ms 2	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No		rican Indian,
9	or Ite		1 Never Married 2 Married 1 Yes 2 XNo		Rican, etc.)		e, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene are instural," or Items 23a or 28a-f show with the Medical Examiner must be notified at	Completed by	3 XWidowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 📉 No Specify:		Specify:	nite
2-0	72 h "natu dical	ete	(Specify only highest grade completed) ! (Give	dent's Usual Occupation kind of work done during most of work	ring	16b. Kind of Business/	Industry
121	within sne.	m D	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
2	Hygie Hygie Ther 1		12 Homem 17. Father's Name (First, Middle, Last)		a /First Middle	Maiden Surname)	
ano	antal l	Be C				waiten Surrame)	
Maryland	hould Me mark	2	Joseph Earl Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Maili	Mary Dra		er City or Town State	Zin Codo)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health Hygiene. Importament of Health Hygiene. Important: If the X1 is markled other than "natural", or frems Z3a or 28a-f show any injurt: If other traumatic event, the Medical Examiner must be notified at once.			Black Star Circle			L045
ē,	f Hea f Hea item		20a. Method of Disposition 20b. Place of Dispo		Date	20c. Location - City or	
30	Page: ent o nt: If i		1 Double 2 Colemation 3 Themoval from State	1	. /2007	TT - 1 4 1	0.0
Baltimore,	ortan		Fleasailt	Grove Cem. 04/23 2. Name and Address of Facility Bro	5/200/ incficio	Walterboro,	SU P A
m	permi Depa Impo any ir once			2955 Hollywood Roa			
b			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Jose Faller	10 >		Onset and Death
1	/Medical		resulting in death) a. Due to (or as a consequence of):	my fam.			Lang
8	Examiner		Sequentially list conditions b.	mona	_		talky
	D #5	iner	Sequentially list conditions, if any, leading to immediate process that the think the state of t			150	
	ecute and -trans	Examiner	that initiated events				
60,	be ex cian a		Due to (or as a consequence of):				
68760,	tificate be executed g physician and as the burial-transit	edical	d				·
	certif nding use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of del	ivon
ĕ	death cert attending	ciar	in the past 12 months? 1 Vec 2 Mark 12 months? 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.O. Box	the cachec	Physician/M	9 ☐ Unknown				
٠ <u>,</u>	The law requires that the death cer te has been signed by the attending 2 should be detached for use	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Records,	w require				1 🗆 1	Yes 2. No 3. Pr	obably 4 □Unknown
900	aw re	plet	Dementia		24a. Was		topsy findings available
ř	The I te ha	Completed			autop perfo 1∐ Yes	rmed? death?	completion of cause of 2 ☐ No
Vital	lan: rtifica ctor, p	Be C	25. Was case referred to medical	26. Place of Deat			2 140
	hysic nis ce direc	70 2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	other: 4 Nursing Ho	ome 5 ☐ Resid	dence 6 □Other (Spe	cify)
Division or	Attending Physician: r death. ector: Atter this certific. by the funeral director,		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury 28b. Time	f 28c. Injury at Work?	28d. Describe I	now injury occurred	
sio	tendl eath. tor: A	cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
5	A P P P	Ę	4 ☐ Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (8 City or Tox	Street and Number or Ru vn, State)	ıral Route Number,
=	in the	E					
	pltal or unrs after eral Dire	Certification:	200 Cortifier 1 Cortifieing Physician To the heat of multipopulates decided	h oo ward at the time at the conduction		4.5.	
Ö	Hospital or 24 hours after Funeral Directely filled in the		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the red at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
Ö	o the Hospital or vithin 24 hours after or the Funeral Direction of the Funeral Direction of the filled in the funeral of the filled in the fi	Medical Certi	(Check only 2 ■ Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, ivestigation, in my opinion, death occur	red at the time,	cause(s) and manner as date and place, and due 29d. Date signed (Mont	to the cause(s)
ā	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, gage 2		(Check only one) 2 L J Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time,	date and place, and due	to the cause(s)
ā	To the Hospital or within 24 hours after To the Funeral Dire completely filled in the Funeral or the Funeral Direction of the Funeral Direction of the Funeral Order of the Funeral Direction of the Funeral Order of the F		(Check only one) 2 L J Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur 29c. License number D641	red at the time,	date and place, and due	to the cause(s)
	To the Hospital or, within 24 hours after To the Funeral Dirthe Completely filled in the Complete of the Compl		29b. Signature and tile of certifier 29b. Name and ad hiss of person who com, eted cause of death litem 23a) (Type,	29c. License number D 0641 Print)	Pred at the time,	date and place, and due 29d. Date signed (Mont.	h, Day, Year)
	 Sta	Medical	29b. Signature and title of certifier 30. Name and ad 1 ss of person who completed cause of death litem 23a) (Type, James P. Jarboe, M. D. 24035 Three N. 31. Date filed (Morth, Day, Year) 32. Registrar's Signature	vestigation, in my opinion, death occur 29c. License number D641	Pred at the time,	date and place, and due 29d. Date signed (Mont.	h, Day, Year)
		Medical	29b. Signature and tile of certifier 29b. Name and ad hiss of person who completed cause of death litem 23a) (Type, James Py Jarboe, M.D. 24035 Three N	29c. License number D 0641 Print)	Pred at the time,	date and place, and due 29d. Date signed (Mont.	h, Day, Year)

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1- State Registrar Amend #10a & #10c per FH/PHYS 04-13-2007 CNM

Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4 Month Year Physician 200 /Medical cility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THINE / TRUNDO HRUNDEL MEDICAL CENTY HNNAPOLIS If Under 1 Year If Under 24 Hrs. 5. Social Security Number 578 - 28 - 3673 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, **Funeral** Year Hours 1 M 2 ♥ MARY FREDERICK MS Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Washington ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at D.C. WASHINGTON 1 Yes 2 No Director Of 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5 2001 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: BL Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 ₩Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) TOWARD EEDIN Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HENIDEASON Gu 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ANCEHIELA DOWLE MS. 20120 20b. Place of Disposition (Name of cemptery, crematory, or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State FRED. MD -10-07 AIRVIQU CEM 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur & Funeral Service Lice 1 epermit. 22. Name and Address of Facility ROLLINS FUNEPAL HOME S7. mes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one caus — n ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last . u. to (ur as a consequence of) Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2. No detached 9□Unknown 9 Unknown been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe certificate 1□ Yes 2□No To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner?
1 ☐ Yes P No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Inpatient 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760,

State Registrar determined

1 3

2007

title of certifier

and manner stated

4 Homicide

29a, Certifie (Check only one)

29b. Signatur

31. Date filed (Month

🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

7028

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of	Marylar	nd / Depa	artmei <i>rtifica</i>	nt of H te of L	ealth a	and Mo	ental Hyg	jiene 10g. No.	00	7	13529
13	Physici	an	1. Decedent's Name	(First, Middle,	Last)							2. Date of Dea April			X98ro =	3. Time of Death
4 /	/Medic				lliams							April	11'		2007	8:20a м
	Examin	er	4a. Facility Name (If r		-			4b. City	, Town, or		of Death		4c.	County o	f Death	
100	We had	William .	Angels Ale 5. Social Security Nur			7. Age (In yrs.	last hirthday	If Unde	Elkr or 1 Year	idge If Under	24 Hrs.	8. Date of Birth			oward	ce (State or Foreign
	Funeral Director		577-24-30		1□M 2MF	89	Ven	Months		Hours	Min.	(Month, Day March 2	, Year)		Vir	ginia
	D		Usual Residence of D	ecedent				1				Mar Cit 2	., I.	310		
	srylar show	<u>.</u>		10b. County		10c. Ci	ty, Town or Lo		~ ' '						100	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f	Director	Md.		ard		Ellic									
	with II		10e. Street and Numb					10f. Zi	p Code				10g, Citiz	zen of Wi	hat Countr	y?
	eath ie 23	Funerai	9615 Spa	arrow C	12. Was Dece	dent Ever in I	19 13	Was Doc		1042	igin? (Sne	ofy Yes or No.	1	USZ 14 Bace	A - Americar	n Indian
	Iter d	F.	1 Never Married	d 2√√Marrie	Armed For	ces?	7.3.	If Yes, spe	cify Cuba	n, Mexicai	n, Puerto F	cify Yes or No- Rican, etc.)			, White, et	c.
036	urs a	þ	3 Widowed 4		If Yes, Give Year or Da	9		1 🗌 Yes	2€ No	Specify:	:			Specify:	Amer Indi	
2	within 72 hours atter death with the Maryland ene. Then "neturel", or iteme 23a or 28a-f ehow ha Madical Examinar must be notified at	Completed	(Specify	5. Decedent's	Education grade completed)		16a. Dece	dent's Usi	ual Occupa	ation	st of workin	00	16b. Kir	nd of Bus	iness/Indu	
2	ithin and and and and and and and and and an	npie	Elementary/Second		College (1-	4or 5+)	life.	DO NOT	ise retired)	, 0, 1,0,1,1,1	.9		O	Homo	
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Maryland 21215-0036	ntal H	Be										(First, Middle,)	
Ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importance of Health and Mental Hygiene. Introduce 33a or 28a-f show important: if Item 27 is marked other than "naturel; or items 23a or 28a-f show eny injury or other traumatic event, the Muzilsal Examinar must be reduited at once.	ပို	19a. Informant's Nam	es Mill			19h Maili	na Addres	s /Street a			en Fitz			State Zin C	ade)
-	th an traul		Ellen Wil									tt City				,000,
อ์	Health tem 27 to		20a. Method of Dispo			20b. I	Place of Disponentery, create					ate			City or Tow	n, State
و ا	Pages nent of I ant: if Ite ury or of		1 ☐ Burial 2 🕃 4 ☐ Donation 5		3 □Removal from S	Male					1/12/	2007	Cata		11-1	M.J.
Baltimore,	permit. Pag Department Important: eny injury o		21. Signatore of Fund			1.15	2	2. Name a	nd Addres	s ol Facili	#/13/ Marr	2007 V H.Wit	zke!	onsvi 'c Fa	milv	F.H.Inc.
ñ	Depa Impo eny i		> Umn	he'f.	Uma	U MOC	845 4	112	old c	olum	oia P	ike Ell	icot	t Ci	Ltv.M	d.21043
8	,	2011	23a. Part1. Enter the shock, or heart Immediate Cause (Fi	failure. List o	nly one cause on ea	ich line.	th. Do not en	ter the mo							1	Approximate nterval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		a	Stage or as a consec		<u> </u>						.		yrs
W.	Examiner				Hype	ertensi										yrs
	2 90.	ner	Sequentially list conditions if any, leading to imm	litions, rediate		or as a consec										7
	ocuted nd transi	Examiner	cause. Enter Underly Cause (Disease or in that initiated events		Ç	al Fib		ion								yrs
Ď,	sate be executed hysician and the burial-transit		resulting in death) La	st		or as a consec										
8/60	ate b	dlcai		,	d. Hypc	thyroi	a									yrs
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 9 ☐ Unknown	onths?		nth 2 ☐ Feta ant at time of c	aldeath 3	⊒Ectopic μ □ Other (s	pregnancy				2	3d. Date Mont	of delivery	r Year Year
J.	res that igned by be deta	by Ph	Part II. Other signific	ant condition	s contributing to de	ath but not res	sulting in the u	nderlying	cause give	n in Part	1.	23e. Did to	bacco us	se contrib	oute to the	cause of death?
202	w require been sig should b	ed b	Depress	ion, an	emia,oste	oporos	is					1 □ Y	es 2[]No 3	B Probab	oly 4 HUnknown
ပ္သ	awre s bee 2 sho	piet	Coronar	v arte	ry diseas	e						24a. Was a		24b. W	ere autops	y findings available
Vital Records,	The law cate has page 2 (Completed		_	eal reflu		ase					autops perfor	med? 2 No	de	ath?	oletion of cause of
<u>g</u>	iician: Th certificate rector, pag	Be C	25. Was case referre	d to medical						26. Place	e of Death	(Check only or				
> 5	Physic this ce al dire	To [1 ☐ Yes 2 XN	0			ER/Outpatier	nt 3 🗆 D	OA Othe	9E 4 🗗 ¥Nt	ursing Hom	ne 5 ☐ Resid	ence 6	Other	(Specify)	
_	ding Pt h. After th funeral		27. Manner of Death 1 XNatural	5 Pending	28a. Date o (Month	f Injury n, Day Year)	28b. Time o Injury		28c, Injury Work	at ?	2	8d. Describe h				
<u> </u>	Attendia death. ctor: A y the fu	cati	2 Accident	investiga	t he			М		∕es 2□						
DIVISION	Mospital or At 24 hours after o Funeral Directed by etely filled in by	Certification:	4 Homicide	determin	ed 288. Place	of Injury - At h g, etc. <i>(Speci</i>		eet, facto	ry, office		2	8f. Location (S City or Town	treet and n, State)	d Number	r or Rural I	Route Number,
	To the Hospital or Attending Physician: which 24 hours after deals to the Funeral Director: Attenthis certification to the Funeral Director; Attential director, completely filled in by the funeral director,	ledicai	(Check only 2 one)	☐ Madical E:	Physician: To the xaminer: On the ba and mann	sis of examina	owledge, deat ation and/or in	vestigatio	n, in my op	oinion, dea	nd place, a ath occurre	nd due to the cod at the time, d	ause(s) late and	and man place, ar	ner as stat nd due to ti	ed. he cause(s)
	To the To the comple	Σ	29b. Signature and tit	le of certifier	0.1	11,	Inn	11 25	c. License	number		2	9d. Date	signed	(Month, Da	ay, Year)
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			30. Name and addres										_			
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1	Sta Registr		or. Date med (world)		2007	Heres	1	La	all s							

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ORIGINAL

Division or Vital this After t ai or Attending P safter death. Director: within 24 hours a

examiner?	red to medical			26. Place of Dea	ath (Check only one)
	No	Hospital: 1 🙀 Inpatient 2 🗆	ER/Outpatient 3□	DOA Other: 4 Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Dea 1 X Natural 2 Accident	5 ☐ Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined			tory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier	1 Certifying Ph	nysician: To the best of my kn	owledge, death occur	red at the time, date and place	e, and due to the cause(s) and manner as stated.

29b. Signature

(Check only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

D25886

MARYLAND 21204

LILIA CEBALLOS, 31. Date filed (Month, Day, Year) State

Certification:

APR 1 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Henry N. Williams 1- For State Certificate of Death Reg No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0705 hrs WILLIAMS HENRY N. Medical Examiner March 7, 2007 4c County of Death 4a Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death University of Maryland Medical Center Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director July 11,194 1 Country) 62 1X M 2 F 214-42-7339 Yrs Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 No f show Baltimore MD Director 10g. Citizen of What Country? s 23a or 28a-f e notified at or 10f. Zip Code 10e. Street and Number 2131 Annapolis Road 21230 U.S.A. 14 Race - American Indian, Black, Funera 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married Yes 2 X No Black 4 Divorced If Yes, Give Year 1 Yes 2 X No specify Specify 3 Widowed \$ or Dates: 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) leted during most of working life. DO NOT use retired) t Pages I and 2 should be filed within 72 ht tempt of Health and Mental Hygiene tant; If item 27 is Elementary/Secondary (0-12) College (1-4 or 5+) nt: If item 27 is marked other than "other traumatic event, the Medical Compl Horse Groomer Racetrack 12th 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Inez Williams Lawson Garnett, Jr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9346 Canterbury Riding, Laurel, MD 20723 Elsie L. Matthews (Aunt) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 3/20/07 Crownsville, MD MD Veterans Cem Important: Donation 5 Other Specify 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. Signature of Funeral Service Lic 246 N. Washington St, Rockville, MD 20850 Approximate Interval nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Eg Physician Between Onset and st only one cause on each line Death Medicai a. Hypertensive Atherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical attending physician a or use as the burial -AMENDED UNPENDED certificate be Box 68760, 23d Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth 2 Fetal death past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 된 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. ğ 1 Yes 2 No 3 Probably 4 Unknown Cocaine Use Records, Completed 24b. Were autopsy findings available 24a Was an has been prior to completion of cause of autopsy performed? death? Yes 2 V N Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical of Vital Be Other₄ Hospital: 1 Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 DOA this 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death Certification: 1 V Natural 1 Yes 2 No 5 Pending the Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie March 7, 2007 O.C.M.E. and address of person who completed cause of death (Ite 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner

State

Registrar

31 Date filed (Month Pey, Year)

32 Kegistrar's Signature

2007

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760.

with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur Registrar

Medical State

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29b. Signature and title of certifie

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Anil K. Shah, M.D. 24035 Three Notch Road, Hollywood, Maryland 20636

APR 1 7 31. Date filed (Month)

29a. Certifier

(Check only one)

7-03022 Mala

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rsicia			ecedent's Name (First, Middle		una							A	nonth pril 20, 20	007			735 hrs
, (amir	e.	4a F	Malachi Ian acility Name (if not institution	give stree	ung t and nu	mber)			City, Town		cation of I	Death	¥	4c. Co	unty of Dea	ath	
	н		Saint Mary's Hospital						eonardt			- in lo	. Date of Birt		•	Birthplac	e (State or
Funeral	7	5. S	ocial Security Number	6. Sex		7. Age (In yrs. la	st birthday)		f Under 1 `Months [Year Days	If Under:	Min.			I ⊢or	reign	
Director		2	14-77-6149	1 X M	2F			rs.		29]	<u> 10/22/</u>	<u> 2006</u>		Country	Maryland
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any	Ī	10a	State 10b. County													1	Yes 2 X No
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Maryla 28a-f d at o	Director												١,	Jnite	d Sts	ates	
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "uatural", or items 23a or 28a-f show natic event, the Mc Iteal Examiner must be notified at once.			.013 Great Mil	1s Ro	oad,	Apt. V5 cedent Ever in U		Mina D	2065	of Hiens	anic Origi	n? (Speci	fy Yes or No		. Race - Ar	merican I	ndian, Black,
h with	Funeral		Marital Status X Never Married 2 Ma		Armed F	orces?	J. 101	If Yes,	specify C	uban, I	Mexican,	Puerto Rio	can, etc.)		White, et	ic.	
partitions, and should be filed within 72 hours after death permit. Pages I and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "uatural", or iter injury or other traumatic event, the Mental Examiner must injury or other traumatic event, the Mental Examiner must	Ψ			orced If Yes	Yes s, Give Ye	2 X No	1		es 2 X						ecify: I		
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nould id Me is ma rtic ev	ို	L	a. Informant's Name/Relations				210	13	Great	Mi	ills	Road	nd 20	1653			
d 2 shalth an m 27 auma			Kaleena Young a. Method of Disposition	/Moth	er_	20b.	Place of Di	spositi	ion (Name	of cem	netery,	LYLA	Date	20c. Lo	cation - Ci	ity or Tov	vn, State
slan of Hee If ite		1	X Burial 2 Crematio	n 3 🗌 F	Removal	from State	crematory	or othe	er place)	. 1	0	04.12	5/200	Cra	at Mi	i 11s.	Maryland
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eparti npor	١	21	. Signature of Funeral Service	Licensee	1	Timi	~	22	055 11	1011	*****	d Ros	ad. Le	onard	ltown	. MD	20650
	ᅪ	K	yle S. Simons a. Part I. Enter the disease, c	MO1 r complicat	206 tions that	caused the deat	h. Do not e	nter the	e mode of	dying,	such as o	ardiac or	respiratory а	rrest, shoc	k, or heart	t	Approximate Interval Between Onset and
icianئ Medicaر		1	failure. List only one caus	C		unexplai											Death
Examine		in o	nmediate Cause (Final diseas r condition resulting in death)	e a. Due	to (or a	s a consequence	of):	د دیا	<u> </u>	<u>unic,</u>							
			equentially list conditions,	b.							-					+	
	ā	if	any, leading to immediate ause. Enter Underlying Caus	Due	to (or a	s a consequence	of):						_				
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oc, ate be hysici	200		FEMALE:		23c. If ye	es, outcome of pr				- 3		oic pregna	ncv		Month	Da	y Year
BOX 68 / 60, e death certificate be the attending physic	as a	Physician in	Bb. Was decedent pregnant in past 12 months?	the		ve birth egnant at time of	death 5		tal death her (Spec	ifv)		,					
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that the desired by the st			Part II. Other significant con	ditions co	ontributir	ng to death but no	ot resulting i	n the u	underlying	cause	given in l	Part I.					ibly 4 Unknown
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SOFC law re	- Shc	힐												erformed? es 2 N	1	✓ Yes	2 No
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of Vital Recoing Physician: The law After this certificate has	rector	mĭ	examiner?	Ho	spital: 1	Inpatient 2	✓ ER/Out	patien	nt 3 🔲 🗆	OOA	Other ₄		ng Home 5		ence 6	Other	
FXi Physi er this	ral di	위	1 ✓ Yes 2 No 27. Manner of Death		28a. I	Date of Injury	28b. T	ime of	Injury		jury at W		28d. Desci				•
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SiO Atten r deat	by th	cat	Z X	nvestigation Could not be	280	Place of Injury -	At home, far	m, stre	eet, factory	y, office	building	, etc.	28f. Locati	on (Street va, State)	and Numb	DAT.	ral Route Number, C exington Par
Division of Vital Records, tal or Attending Physician: The law requings after death. al Director: After this certificate has been since the content of the	ed in	Ē	3 dicide	etermined	(Spe	(CIIV)	dence										
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Division of Vital Records, P.O. Box 68/60, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici	completely filled in by the funeral director, page 2	Medical Certification:	(Check only one) 2 Medical	Examiner:	On the b	e best of my know asis of examinationer stated.	on and/or ir	vestig	auon, m	у орин	011, 4004		at the time,				nth, Day, Year)
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~-			Danil	Le	01	nin				0.0	C.M.E.			Ap	"III Z 1, Z		
			30. Name and address of pe	rson who c	omplete	d cause of death	(Item 23a)			C4:	A Dele	more !	ND 01001				
			Tasha Greenberg		ssista	nt Medical E	xaminer	11			et, Balti	more, N	1D 21201				
	_	مؤه	31. Date filed (Month, Day Y	ear)		32. Redistrar's Si	gnature		Sand	t a							

Registrar

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				For State	State o	f Marylar				lealth a		lental Hy	giene	007	135	34
				Registrar 1. Decedent's Name (First, Middle, L.	ast)							2. Date of Dea			3. Time of	Death
		Physici	an	Mary A. Zell								Month 4 / 2 1 /	Day	Year		РМ
	1	/Medic		4a. Facility Name (If not institution, gi		mbor)		4h City	Town	r Location of	of Death	4/21/		County of Deat		Г
	1	Examin	er								JI DOMIII					
				Homewood at C 5. Social Security Number 6.	rumlano Sex	7. Age (In yrs.		Fre		I C K	24 Hrs.	8. Date of Birt		rederi		r Foreign
		Funeral Director			1 ☐ M 2 🕱 F	9 2	Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Da 7 / 1 8 / 1			nplace (State o untry) A	, , o, o, g, ,
_				Usual Residence of Decedent		7 2						//10/1	714		Α	
10		land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside Ci	ty Limits
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	93	al', o	þ	3 X Widowed 4 ☐ Divorced	If Yes, Gr Year or D			1 LI Yes	ZALI NO	<i>Specify:</i>				Specify: W	hite	
	5-0036	72 hours after death with the Maryland natural', or items 23a or 28e-f ehow dissa Examiras must be notiliad at	ted	15. Decedent's E (Specify only highest g	Education		16a. Dece	dent's Usua	al Occup	ation	t of work	ina	16b. Kin	d of Business/	Industry	
	21	within one.	g	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u	se retire	during mos d)						
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	nd	be filed ital Hygi of other event, I	Be	17. Father's Name (First, Middle, Las	st)					18. Mothe	er's Nam	e (First, Middle,	Maiden S	Sumame)		
4	la	should bent and Ment marked	၉	Jacob Yanick						Anna	a S	merkow	ısky			
$\stackrel{\cdot}{\simeq}$	Maryland	2 should be and Mental I is marked or sumatic eve		19a, Informant's Name/Relationship			19b. Maili	ng Address	(Street	and Numbe	er or Run	al Route Numbe	er, City or	Town, State, 2	Zip Code)	
0D: 4/21/D		5 = 2 :	١.,	Carolyn Kimbe	rlin	Dau	and the second second				-	Circl				1702
7	S.	97 -		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3	□ Bemoval from	State 20b.	Place of Dispo cemetery, cre	osition (Nar matory or c	ne of other plac	сө)		Date	20c. Loc	ation - City or	Town, State	
10	Ě	Peg nent ant: i		4 Donation 5 Other (Spec			Fayet	te M	em 1	Pk /	4/25	/2007	Bri	er Hil	1. PA	
9	Baltimore,	permit, Pege Department of important; if any injury or once.		21. Signature of Funeral Service Lice	ensee		2	2. Name ar	nd Addre	ss of Facili	ty Ke	eney 8	Bas	sford	P.A.	F.H.
	8	80 E 8 8		phe C. XX	and	M011	76 1	06 E	ast_	Chui		St. Fr				
9				23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that	caused the dea	th. Do not en	ter the mod	e of dyin	ng, such as	cardiac	or respiratory ai	rrest,		Approximat Interval Bet	e ween /
4	-	Physician		Immediate Cause (Final	/	Ny	411	ZI	. 4	16/1	16				Onset and	Death
- 1	1	/Medical		disease or condition resulting in death)	a. Due to	(or as a consec	quence of):	1017	n	912	100				2 0	01/00
	п	Examiner		Party contract respect to the second	h	/										
		_	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		(or as a consec	quence of):									
2)	de	te be executed ysicien and e burlat-transit	Examiner	Cause (Disease or injury that initiated events	C.											
ゴ	0,	exe en ar rial-t		resulting in death) Last	Due to	(or as a consec	quence of):									
3	,092		cal		d											
50	68	eath certificat attanding phy I for use as the	Jed	IE EENALE										1		
5	ŏ	th ce andia	25	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		⊒Ectopic p	regnanc	v			2	3d. Date of del	•	Year
ನ	B.	dea death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Other (sp		<u> </u>				Month	Day	rear
5	Ö.	thet the death ed by the atta detached for	by Physician/Med	9 🗆 Unknown												
00	s, l		À	Part II. Other significant conditions	contributing to d	leath but not re	sulting in the u	anderlying o	ause gn	ven in Part	l.				the cause of c	
2	Records,	w requires been sign should be	ed	HY178/47/104								10,	Yes 2□	JNo 3∐Pi	obably 4	dnknown
\succeq	၁	aw re as be 2 sh	pie	Domunty	71							24a. Was autop		24b. Were au	topsy findings completion of a	available
- B	æ	The la	Completed		1							perfo	rmed?	death?	2□ No	
-0	Vital	ician: Th certificate rector, pag	a a	25. Was case referred to medical					-	26. Place	e of Deat	h Check only o	one)			
13	-	\$	ToB	examiner? 1 Tes 2 No	Hospital: 1 🗆	Inpatient 2	ER/Outpatie	nt 3 DE	Ot Ott	TOP.	ursing Ho	me 5 ☐ Resi	dence 6	□Other (Spe	city)	
5	n of	tending Phy leath, tor: After thi the funeral	Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o	of a	28c. Inju	ry at		28d. Describe				
0	Ö	Attending r death. ector: After by the fune	atic		on			М]Yes 2□	No					
T	Division		Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	A 200. FIAU	e of Injury - At h ling, etc. (Speci	nome, farm, st	reet, factor	y, office			28f. Location (: City or Tox	Street and wn, State)	Number or R	ıral Route Nun	nber,
3		ital or rs afta rai Dir led in		//												
Anguntophysicianas		To the Hospital or Al within 24 hours after or To the Funeral Directompletely filled in by	cai	(Check only 2 Medical Ex		pasis of examin	owledge, deal ation and/or in	th occurred	at the ti	ime, date ar opinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s	s)
X		To the h within 2. To the F complete	Medicai	29b. Signature and title of certifier	and mar	nner stated.		20.	c Licos	se number			29d Date	signed (Mont	h Day Your	
		To To		230. Signature and titleyor certifler		/-	1	_					Zou. Date	7 ?	∧ 17	
				MA	V7 (An	1	0	D 3	16428	3 			1/4)	U	
		Ø		30. Name and address of person wh											ı	
				Casper E. Clitt 31. Date filed (Month, Day, Year)		M . D		est P	lint	th St	. F	rederi	ck M	1D 217	01	
	ă	Sta Regist		APR 2. 6. 2	- 1	ares a	4 do	anti)								

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible

			For State Registrar	State o	f Marylan	d / Depa		t of H	ealth a		ental Hy	giene	007	13535
			Hegistrar Decedent's Name (First, Middle,	Last)			Tinoan		Joann		2. Date of De			3. Time of Death
								APRIL 25, 2007 Year			1:30a M			
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death FUTURECARE IRVINGTON BALTIMORE								4c. Co	ounty of Death	1	
	Funeral Director	700	5. Social Security Number 220–07–7850	5. Sex 1 □ M 2 X F	7. Age (In yrs. 93		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 6-24-	1913		nplace (State or Foreign Intry) YLAND
	yland iow at		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside City Limits
	e Mar la-f st tiffed	Director	MD. N/A		В	ALTIMO	RE							1√Yes 2□No
	vith th	Dire	10e. Street and Number		_		10f. Zip					10g. Citizer	n of What Cou	untry?
	eath v	Funeral	2325 W. LAFA		edent Ever in U.	S. 13.	1	21216 dent of Hi		gin? (Spe	cify Yes or No		Race - Amer	ican Indian,
980	be filed within 72 hours after death with the Maryland that Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	orces? 2∑No ve		If Yes, spec				cify Yes or No Rican, etc.)		Black, White pecify: BL	
Maryland 21215-0036	within 72 ho ene. than "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						ng		of Business/I	·		
121	e filed within al Hygiene. other than ' vent, the Me		-12- 17. Father's Name (<i>First, Middle, L</i>	-0-		MI	ECHAN]	IC	10 Matha	wa Nama	(First, Middle		IRPLAN	E
yland		To Be	BOYD SHEFFEY	asi)							RA LUST		irriarrie)	
Mar	\$ ₽ E E		19a. Informant's Name/Relationshi		re)	1	•	•			I Route Numb			ip Code) AND 21216
Baltimore,			20a. Method of Disposition		20b. P	Place of Dispo					ate		tion - City or	
limo	. Pages Iment of I tant: If Ite Jury or o		1 ☐ Burial 2 🖫 Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	MET	RO CRI	EMATO	RY	-				-	MARYLAND
Ball	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service L	icensee IONA	AB.									YLAND 21217
	Physician /Medical Examiner		23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, of heart failure. List only one cause on each line. Immediat Vause (Final disease or condition a. Colon AR ARTER DISEASE Foundable 1 Foundab											
			resulting in death) Due to (or as a consequence of):										7760 444176	
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
7,092	icate be executed physician and s the burial-transit	I Exan	that initiated events resulting in death) Last	c	(or as a consequ	uence of):								
6876		dical		d										
Vital Records, P.O. Box 6	The law requires that the death certil ate has been signed by the attending page 2 should be detached for use a	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown							23d. Date of delivery Month Day Year		*		
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown					
											1□ Yes	psy prmed? 22No	24b. Were au prior to death? 1 □ Yes	topsy findings available completion of cause of
Ξ		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	Innationt 2 🗆	EB/Outpation	nt 3 🗆 DC	Othe	or s		Check only		70**** (0	-16.4
יסר	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	n: To	I impatient 2 Evolupatient 3 DOA 42 Nursing Home 5 Hesidence 6 Dother (S)										<i>y)</i>	
Division		Certification:	2 Accident investigation M 1 Yes 2 No						8f. Location (Street and Number or Rural Route Number, City or Town, State)					
۵	Hospital or the hours after Funeral DI tely filled in	ledical Cer	(Check only 2 ☐ Medical E	Physician: To the	e best of my kno	wledge, deat	th occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s) ar	nd manner as	stated.
	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier		nner stated.		290	c. License	number				signed (Monti	
	1,		30. Name and address of person v	who completed cau	M) se of death (Item	n 23a) (Tvpe.		Doc	626	34		4/2	5/07	
	N		MATERNA	turn 1	0802 1	+1CK62		NE	RD	Col	UMBIA	MI	210	944
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 7 2007	32. F	Registrar's Signa	ature	0							
						7								

DHMH 17 Rev 1/2001

07-03067 Jason Todd Abel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1	1- For State Amend #20a-c &22 Per FH C867 54344 Suite	∄ f Death	Reg	. No.						
Physicia		1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death						
led∺al Exami	ner	Jason Todd Abel		April 22, 20	07 (156 hrs						
,		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death						
		307 South Lehigh Street	Baltimore								
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		_	(MM/DD/YYYY) 9. Birthplace (State or Foreign						
Director	J.	218-94-1313 1XM 2 F 29	Yrs. Months Days Hours Min	Oct 28,	0-11-1-1						
		Usual Residence of Decedent									
any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									
1807 ryland a-f show a		MD Balt:	imore		1 X Yes 2 No						
180 faryland 28a-f show	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?						
th the Maryland 23a or 28a-f sho	ä	816 E. 41st Street	21218	1	USA						
with ns 23 se ng	Be Completed by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (5		14. Race - American Indian, Black,						
Jeath r iten		1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	. White, etc.						
after (3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:		Specify: white						
hours after 'natural'', Examiner			dent's Usual Occupation (Give kind of g most of working life. DO NOT use re		16b. Kind of Business/Industry						
72 h		Elementary/Secondary (0-12) College (1-4 or 5+)		is out							
5-0036 led within 72 Hygiene. other than		unk	disabled		none						
F. Hygi		17. Father's Name (First, Middle, Last) Charles Victor Abel		ne (First, Middle, Ma							
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media			De ailing Address (Street and Number or	bra Buhrn							
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once			3 Fagley Street B								
md 2 salth 2 em 2			sposition (Name of cemetery,		MD 21224 20c. Location - City or Town, State						
nore, MD 21215-0036 ages I and 2 should be filed within nt of Health and Mental Hygiene. It If item 27 is marked other that other transmatic event, the Medii		1 Burial 2 Tremation 3 Removal from State crematory of	r other place)								
im Pag ment tant:		4 Donation 5 West An	ndel Crematory 5/	24/2007	Otlenton, MD						
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		21. Sin Aure of Funera Service License Ale, Director	2. Name and Address of Facility And tate Anatomy Boar	rose lunera	al home Inc Arbutus MD						
		222 Part 1 Enter the discrete or completions that caused the death. Do not an	altimore, MD 212	or respiratory arres	Internal Approximate Interval						
Physician Vedical		failure. List only one cause on each line. Between Onset and									
kaminer		Immediate Cause (Final disease a. IMETNACIONE INTOXICATION and cocaine use									
- 134 ·		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):									
	ē										
	重	cause. Enter Underlying Cause (Disease or injury that initiated									
ed nsit	Examiner	events resulting in death) Last Due to (or as a consequence of):									
760, cate be executed physician and he burial - transit		X UNPENDED AMSNDED 7-390-5 porME									
760, cate be ex physician	Medical	#23a,21-20a-1, perile,	g867, 5/15/07 TT		23d. Date of delivery						
68760, certificate be rding physic		IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic preg	nancy	Month Day Year						
OX 68: sath certiff attending	cia	4 Pregnant at time of death 5	Other (Specify)		1						
Box death cuthe attented for us	Physician	1 Yes 2 No 9 Unknown g Unknown									
P.O. Box s that the death gned by the atte		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		bacco use contribute to the cause of death?						
, P.O.	d by			1 Yes	2 No 3 Probably 4 Unknown						
ords, w requir as been s should	Completed			24a. Was a autops							
e law e has e has	ם			perform	med? death?						
tal Recian: The l		25. Was case referred to medical	26.Place of Death (Chec		, , , , , ,						
lital sician is ceri	B	examiner? Hospital:	Other:		Residence 6 V Other: Scene						
1 of Vital Records, ling Physician: The law requir After this certificate has been s funeral director, page 2 should I	<u>1</u>	27. Manner of Death 28a. Date of Injury 28b. Tim	e of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred						
on C nding th r: Af	Certification:	1 Natural 5 Pending FNd 4/22/2007 1:45	1 Yes 2 X No	unk							
Division lal or Attendi rs after death al Director: /		28e. Place of Injury - At home, farm,			Street and Number or Rural Route Number, City						
Divis ospital or / hours after meral Dire	E E	3 Suicide 6 Could not be determined (Specify) friend's house		or Town, State) 307 S. Lehigh St. Baltimore, MD							
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The thin 24 hours after death the Funeral Director: After this certificate has been signed by the attending physician and npletely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifier Physician To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated									
To the Hos within 24 h To the Fur	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
To To Com	Me	and manner stated, 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)						
		Josh Jeel MO	O.C.M.E.		April 22, 2007						
		30. Name and address of person who completed cause of death (Item 23a)									
		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
S	tate	31. Date filed (Month, Day, Year) 2. Registrar's Signature	who								
Regis		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	vil								

Physician /Medical						Month	Day	real	\mathcal{O}
	Richard E. Abe			4h City Town or	Leasting of De	-104-	90	69 10	8:35 M
Examiner	4a. Facility Name (If not institution,	1 1/1	100100	4b. City, Town, or	Location of De	eatn	4c. County		
Funeral	5. Social Security Number (S. Sex 7. Age	(fr) f(/ e (In yrs. last birthday)	If Under 1 Year	If Under 24 F	rs. 8. Date of Bi	rth	9. Birthplace (S	State or Foreign
Director	213-36-9472	1 X M 2□F	70 Yrs.	Months Days	Hours M	lin. 8. Date of Bi (Month, D Jan 16	, 1937	New Je:	rsey
pug *	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d Inc	side City Limits
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ither than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at a Completed by Funeral Director		re		ingham					⊒Yes 2√∑No
vith the Mar t or 28a-f sl be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		
h with	8554 Westerman	Circle			21236			TICA	
r items 23a	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.			(Specify Yes or Numerto Rican, etc.)	o- 14. Rac	USA ce - American Indi ck, White, etc.	ian,
al", or its	1 ☐ Never Married 2 ☒ Marrie	d 1 ☐ Yes 2 📉 N If Yes, Give	lo	1 ☐ Yes 2X No		actio filoan, ctc.)	Specif		۵
tural' al Ex	3 Widowed 4 Divorced	Year or Dates:		dent's Usual Occup	ation	unk			unl
n "na Aedio	15. Decedent's (Specify only highest	grade completed)	(Give	kind of work done of NOT use retired	during most of t		TOD. KING OF B	usiness/Industry	ulir
ygiene. ter than "natura ter, the Medical E	Elementary/Secondary (0-12) unk	College (1-4or 5- unk	+)						
atal Hy d othe event,	17. Father's Name (First, Middle, L	,			18. Mother's N	Name (First, Middle	e, Maiden Surnan	ne)	
and Ment s marked umatic e						y Belles			
and 2 sn ealth and n 27 is m	19a. Informant's Name/Relationshi Roberta Abel/s					Rural Route Numi)
Healther 1	20a. Method of Disposition		20b. Place of Dispo		Circle	e Notting		21236 - City or Town, St	
Department of Health and Mental Highen. Department of Health and Mental Highen. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 ☐ Burial 2 ☐ Cremation 4 ፟ Donation 5 ☐ Other (Sp.		cemetery, crer	matory or other plac	ce)	Dato	200. Location	City of Town, St	ale
Import any in	21. Signature of Euneral Service L ROMALD S	Wade Dire		. Name and Addre tate Anat altimore.		ard 655 W 1201	7. Balti	nore Str	eet .
	23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caused nly one cause on each lin	the death. Do not ent	er the mode of dyin	ig, such as card	diac or respiratory	arrest,	Appro	oximate /al Between
ysician	Immediate Cause (Final disease or condition	a Acu	te MI					Onse	et and Death
Medical aminer	resulting in death)	Due to (or as a	a consequence of):						
	Sequentially list conditions,	b. CHI)	a consequence of):						
in and rial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Cardi	onsequence on.	hu					
ial-tra	resulting in death) Last	Due to (or as a	a consequence of):	9					
ohysicia the bur	,	d. Diabe	etes Me	ellitus					
d by the attending pletached for use as Physician/Mec	IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Do	to of delivers	
d for u	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	<u>'</u>		1	ite of delivery onth Day	Year
by the stached	9 Unknown	9□Unknown							
e e e	Part II. Other significant condition	s contributing to death bu	it not resulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use conf	tribute to the cau	se of death?
been si should t						_ 1□	Yes 20 No	3 Probably	4 □Unknown
cate has been s page 2 should						24a. Was	ppsy	Were autopsy fin prior to completic	dings available on of cause of
cate , pag						perf 1□ Yes	ormed?	death? 1 ☐ Yes 2 ☐ N	
certificate has trector, page 2 s	25. Was case referred to medical examiner?	Hospital:	44	• 20 DOA Othe	0.00	Death (Check only			
그 말라 그	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatier		I 3 DOA	4 LI Nursin	g Home 5 ☐ Res	how injury occur		
th. : After thi e funeral	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day	Year) Injury	Worl	k? Yes 2 □ No	200. Describe	now injury occur	reu	
ector: After by the fune	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of inju	ry - At home, farm, str. . (Specify)	eet, factory, office		28f. Location	(Street and Numb	per or Rural Rout	e Number,
rs after death. al Director: After led in by the funer. Certification:	- Tiomicide	building, etc	. (Specify)			City or To	own, State)		
io the hospital or Artendi within 24 hours alter death. To the Funeral Director: A completely filled in by the fu Medical Certification	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examination and/or in ted.	vestigation, in my o	pinion, death o	occurred at the time	, date and place,	and due to the c	
To th To th comp	29b. Signature and title of certifier	N	,	29c. License	e number		29d. Date signe	d (Month, Day, Y	'ear)
	1 Chim	Chul	path (Item 23a) (Type,	200	5334	5	4/21	(207	
	<u> </u>	1						, ,	
	30. Name and address of person w	completed cause of de	ath (Item 23a) (Type,	Print)				,	

				For State Registrar		State	of Maryla	ind / Depa <i>Cei</i>			tealth <i>Death</i>			gien Reg. N		10000	
	Phy	sicia	ın	1. Decedent's Name			100				-		2. Date of De Month	ath	av Year	3. Time of Death 10:30 AM	A
		ledica amine		Jeanet 4a. Facility Name (//		XLEY AYE			4b. City	. Town. o	or Location		White a	· ·	lc. County of Death	10.30 A	_
			'	Harfor	d Memo	rial Hosp	ital				de Gr				Harford		
	Fund			5. Social Security N		6. Sex 1 ☐ M 20X F		s. last birthday)		Days	If Unde Hours		8. Date of Bir (Month, Da Aug • 10	th y. Yea	9. Birthp County 1929 Mary	lace (State or Foreig	n
	*			214-26-69 Usual Residence of				//	1				Aug. IV	<i>J</i> , .	LJZJ IMLY.	LOUIG	
,	arylan			10a. State	10b. County		10c. (City, Town or Lo	cation						1	Od. Inside City Limits	
20	1215-0036 within 72 hours after deeth with the Maryland ane. than "natural", or Itama 23s or 28s-1 ehow	EXAMPLE COMPLETE CONTROL OF	Director	Maryland	Harfo	ord	Ha	vre de (ip Code				100.0	Citizen of What Coun	1 2 Yes 2 □ No	
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7	Baltimore, Semit. Pages 1 el Depertment of Nee mportant: If Item	DOCE.		20a. Method of Disp		3 □Removal from		Place of Dispo cemetery, crer	sition (Na	me of			ate		Location - City or To		
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	Physic	ian	İ	Immediate Cause (disease or conditio	Final	only one cause on	each line.	- Sh	OCI	6					a de la companya de l	Interval Between Onset and Death	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Amonth 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** bry 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and numb or Location of Death **Examiner** Baltimone If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 😡 F 78 5-24-1928 Director MARÝLAND 220-16-6994 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at BALTIMORE ROSEDALE MD Director 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or 7 7941 OAKDALE AVE 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? nem 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X☐ No Specify: WHITE Completed by Specify: 31 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be IVA ၉ (REEL) ARLIE REED 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 21111 4037 OLD YORK ROAD FREDERICK BURES/SON MONKTON, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 □ Cremation 3 □ Removal from State ö Department o Important: If any injury or GARDENS OF FAITH 4-28-07 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21237 CHESACO AVE ROSEDALE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □ Ectopic pregnancy Month 4☐Pregnant at time of death Year Day 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy dronari 2 **7** No 1∐ Yes Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 M Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Baltimore, Maryland 21215-0

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

StateRegistrar

31. Date filed (Month, Day,

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Square brive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 26 per doc 9866 4-27-07 vt. State of Maryland P Department of Health and Mental Hygierie | | | | Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death APRIL **Physician** 2007 11:15 PM JOHN GERARD BRENNER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Abingdon

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Harford 1202 Hidden Stream Court 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**X** M 2□ F Yrs. 69 219-32-7820 Jan. 8.1938 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Baltimore County Baltimore Maryland Directo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20 Sandstone Ct. 21236 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? XXIYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: White ģ 3 ☐ Widowed 4 🎖 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Retail Sales 12 vrs. N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ound be th and Mental h Calvin Brenner Rita Wachter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Richard Stephen Brenner 20 Sandstone Ct. Baltimore, Maryland (Son) 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 5 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4-27-07 Metro Crematory Inc. Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility E. F. Lassahn Funeral Home THO 11750 Belair Rd. Kingsville, Md. 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congested **Physician** 415 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transit Physician/Medicai the use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy ò Day 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Expressive Asphasia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown cerebral VASCUlar accid 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Hypertension
25/Was case referred to medical
examiner? 2 No 1 Yes 2 No 1 Tyes Be 26. Place of Death (Check only one) Ex-wife's home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home The Sidence Other (Specify) 1 ☐ Yes 20 No After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. M 2 Accident the f after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funeral I
completely filled To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and tute of gertifier Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Yard

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Maryland 21215-003(

Baltimore,

o

Records,

of Vital

Division

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 5:30 Behringer 2007 **Ernest** April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charolette Hall Veteran Home Charolette Hall MArys 8. Date of Birth (Month, Day, Year) Feb. 25, 1920 Maryland If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**32** M 2□ F 220-05-8372 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heelth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itema 23e or 28a-f ahov ury or other traumatic avant, the Madical Examinat must be notified at 1 ☐ Yes 2 No Director MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 N. Stuart Street 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 StYes 2 □ No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify: Specify: White Completed by 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter Grocery 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Karl Ernest Behringer 2 Theresa Vollmert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Cooper /daughter 1007 Cockeys Mill Road Reisterstown MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 'Department of Himportant: If its any injury or of once. 1 ☐ Burial 2 📆 Cremation 3 ☐ Removal from State Bayview Crematory 4/26/07 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signatury of Juneral Service License Connelly Funeral Home of Essex 23a. Pary . Enter the disease shock, or heart failure. e Or plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ORONARY disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner OBSTRUCTIVE Pulmonary HRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hy Parthy roid
Due to (or asla bonsequence of): The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Physician/Medical use as the Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No P.0. should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 this certificate 1 Yes 1 Yes 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٤ ŏ hours efter death. uneral Diractor: After this y filled in by the funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred or Attanding Division 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours e To the Funeral 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical сопрівіві and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Janus min 30. Name and address of person the co Prince Fredrick MD20678

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 11:40 a^M 24, 2007 Nina E. Cheuvront Apr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3 Cedar Bluff Court Baltimore Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 1 F 220-42-9583 Maryland 62 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Catonsville Maryland Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 3 Cedar Bluff Court Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black. White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other transment. 3 RN Nursing Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell Rice Helen E. Tull 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3 Cedar Bluff Court, Catonsville, Maryland 21228 David C. Cheuvront / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/30/07 Bayview Crematory Baltimore, Maryland 4 Donation 5 Other (Specify) 21 Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final per Vecto (or as a consequence of): 3 math **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Ents funderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 morths? Month Day Year 5 ☐ Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1□ Yes 2- No certificate To the Hospital or Attending Physician: 26. Place of Death Check onl_one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 6 Residence 6 □Other (Specify) 2 ER/Outpatient 3 DOA 1 📋 Yes 1 🗌 Inpatient 2 this filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? after death. 27. Manner of Death Certification: 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours af **To the Funeral D** completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Heather D. Mannuel 46 900 Coton Avience Bathmere MD 21229 teather D. Mannuel 31. Date filed (Month, Day, Year)
APR 2 7 2007 32. Registrar's Signature

29b. Signature and title of certifier 1

DOS7936

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Year WILLIAM 1737 PM CAMPBELL 04 APRIL 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER BALTI MORE RADAMS CEWLEY SHOCK TRAINS 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 220-18-7631 1 M 2 □ F Director 79 05/20/1927 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD N/A BALTIMORE CITY 1 □XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 624 CHERATON ROAD 21225 USA death v Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 □ Xes 2 □ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black. White, etc. US Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ARMY 1 ☐ Yes 2 ☐ No Specify: ģ Specify:BLACK 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BETHLEHEM STEEL Elementary/Secondary (0-12) College (1-4or 5+) CORPORATION CRANE OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HOWARD CAMPBELL GERTRUDE ANDERSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a sortant: If Item 27 is Injury or other trau 2912 W. LAFAYETTE AVE, NEIL CATES / SON BALTIMORE, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State MD VETERANS CEM. permit. Page Department of Important: If any Injury or 4/12/07 OWINGS MILLS, MD 4 Donation 5 □ Other (Specify) GARRISON FOREST 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service License 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 23a. Fact. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death TRAVMATIC immedia Cause (Final SUBBURAL Physician HEMATOMA BLAIN IN 13 0445 disease or condition resulting in death) /Medical Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 morths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ ANGINA HYPER CHOLESTEROLEMIA Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an certificate 1□ Yes 2 No 25. Was case referred to medical exampler? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation 1 Natural FELL OF LADDER AT 1 ☐ Yes 2 ☑ No 742 PM MARCH 22, 2007 I Director: A 2 Accident 3 ☐ Suicide 6 □ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 624 CHERATON RD 4 ☐ Homicide BALTIMONE, MD HOME 21725 within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) esoulle 17385 2004 AFRIL 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

RUNALD TESORIERO

APR 2 7 2007

31. Date filed (Month, Day, Year)

COWLEY

TRAUMA

SHOCK

CENTER

R ADAMS

32. Registrar's Signature

		-	State of Maryland / Department of Health and State of Maryland / Department of Health and Per FH G867 5/04/07 HH G867 5/04/07	Menta	al Hyg R	Jiene leg. No.	007	13544
40	Physicia		1. Decedent's Name (First, Middle, Last) Charrissa K. Crum	2. Da	te of Dea onth	Day	2007	3. Time of Death $7:05PM$
>	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	ath			Inty of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hr Months Days Hours Min	s. 8. Da	te of Birth onth, Day	1959	9. Birthp Coul	place (State or Foreign
	Ð		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		-			0d. Inside City Limits
	ne Maryli 8a-f sho ptified at	Director	MD N/A Baltimore			10a Citizen	of What Cou	1 MYes 2 No
	th with the 23a or 23	al Dire	10e. Street and Number [612 Wyanoke Avenue] 10f. Zip Code 21218				US4	
36	be filed within 72 hours after death with the Maryland ttal Hyglene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 TNever Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 Yes, Give Year or Dates:	(Specify Yerro Rican,	es or No- etc.)		Race - Americ Black, White, ecify: DIC	
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_	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		20a. Method of Disposition 20b. Place of Disposition (Name of Company of the Com	Date		Winds	or Mil	
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Ä	permit Depar Impor any ir		4905 York Road	Balit	mon	re Mo	21212	Approximate
5	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	nac or resp	matory at			Interval Between Onset and Death
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rds, P.O.	w requires that the death cer been signed by the attendir should be detached for use	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	_ 2	?3e. Did t			the cause of death?
Il Records,		Completed		-	24a. Was autop perfo ☐ Yes		prior to death?	topsy findings available completion of cause of 2 No
Vita	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing				☐Other (Spec	ify)
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Division or Vital	or Atten fter deat director on by the	Certification:	2 Accident investigation 3 Suicide 4 Homicide investigation 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. L	ocation (Street and f wn, State)	Number or Ru	ral Route Number,
	To the Hospital of within 24 hours at To the Funeral Completely filled it	Medical C	29a. Certifier (Check only one) CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and pl. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death o and manner stated.	lace, and d	lue to the the time	cause(s) ar , date and p	nd manner as lace, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier DVJ4JN4 TOMIL M-D. 29c. License number AT24389	110			signed (Monti	n, Day, Year) 3 2007
	1.					,		
	St	ate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOMIC DRAGANA M-D. UNION MEMUR 31. Date filed (Month, Day, Year) 32. Paistrar's Signature	-11-6	- HI	J341	IMC,	MEZLHIUD
	Regist		31. Date filed (Month, Day, Year) APR 2 7 2007 32. Pelistrar's Signature					

			1 - For State Registrar	State of Maryland / I	Department of Health and Certificate of Death	Mental Hygie	C001 10040
	Physic	ian	1. Decedent's Name (First, Middle, La			2. Date of Death	Day Year 3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give		4b. City, Town, or Location of De		4c. County of Death
	Funeral Director		5. Social Security Number 6. 5	sing Facility 7. Age (In yrs. laglib) 87	Bautinut Tithday) If Under 1 Year If Under 24 H Months Days Hours Mi	s. 8. Date of Birth	9. Birthplace (State or Foreign Country) AL
	rryland show	_	10a. State 10b. County	10c. City, Tow			10d. Inside City Limits
	the Ma 28a-1	Director	10e. Street and Number	Bul	timore.	100	1 E Yes 2 □ No Citizen of What Country?
	23a or	ai Di	713 E. 33rd	Street	21218	109.	USA
Maryland 21215-0036	72 hours after deeth with the Maryland natural', or Iteme 23a or 28a-1 ehow Alsel Examinar must be notified at	d by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Standard 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Do If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ Specify:	Specify Yes or No- orto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
15-(thin 72 hours e. an "natural", Medical Exe	ojetec	15. Decedent's Ed (Specify only highest gra	de completed)	Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking 168	b. Kind of Business/Industry
212	¥ 6 ± 2	Completed	Elementary/Secondary (0-12) 3rd grade	College (1-4or 5+)	Domestic		Private
land	d ital	To Be	17. Father's Name (First, Middle, Last,	unk	18. Mother's N	ame (First, Middle, Mai	
lary	2 should and Men Is marke	-	19a. Informant's Name/Relationship (1+	Mailing Address (Street and Number or F	Rural Route Number, C	ity or Town, State, Zip Code)
	ges 1 and 2 should t of Heelth and Men If item 27 Is marke or other traumatic		herca Campate 20a. Method of Disposition	20b. Place of	13 E. 33rd Street Disposition (Name of		nore MD 21218 2. Location - City or Town, State
Baltimore,	Pa men ent: ury		1 ★Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specification)		ry, crematory or other place) 1 emorial Park 04		Vindsor Hill, MD
Ball	permit. Departm Importe any inju		21. Signature of Funeral Service Licer	Suc Suc	22. Name and Address of Facility Vo 4955 York Road	aughn C.Gr	reene Funcial Sentices
	rnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	not enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death Lyears
68760,	ificate be executed g physicien and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of d.			
	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death, within 24 hours after death, the transfer of the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ŪNo 9 □ Unknown	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 9□Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
ords, P	equires that sen signed k ould be det	by	Part II. Dther significant conditions of	ontributing to death but not resulting in	the underlying cause given in Part I.		co use coordibute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Records,	vicien: The law r certificate has be rector, page 2 sh	e Completed	25. Was case referred to medical			24a. Was an autopsy performed	
<u> </u>	hysicie his cert I direct	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	Other	ath <i>(Check only one)</i> Home 5 🗌 Residence	a 6 □Other (Specify)
ono	ding Phys h. After this funeral di		27. Manny of Death 1 Viatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. T	ime of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	njury occurred
Division of	tal or Attending Physicien: The rs after death. In the Director: After this certificate he ed in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital within 24 hours a To the Funeral Completely filled	Medicai	29a. Certifier (Check only one)	vsician: To the best of my knowledge, iner: On the basis of examination and and manner stated.	, death occurred at the time, date and place d/or investigation, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the compli	₩ We	29b. Signature and title of certifier	egregororo	29c. License number	_	Date signed (Month, Day, Year) Pull Zif, 2007
	3		30. Name and address of person who o	ompleted cause of death (Item 23a) (REGIR, 700 W	Type, Print) 40 th STREET, BAL;	*	
	Sta		31. Date filed (Month, Day, Year)	32. egistrar's Signature	1010 301 (201) 10112	1,1,1,1	
DHN	Registra MH 17 Rev 1/20		APR 2 7 200	17 Seems &	greek .		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Paula Davidson 1:45 AM APRIL 26 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hunpital of Baltimore Baltmore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 216-58-0097 58 06/01/1948 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes ¾☐ No Director Baltimore Halethorpe MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 2404 Smith Avenue 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 M Divorced 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Ouality Control** Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilbert Harthausen Elizabeth Racke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kimberly A. Parks (Daughter) 2404 Smith Avenue, Halethorpe, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 04/30/2007 Baltimore, Maryland □Donation 5 □ Other (Specify) Cionature of Euneral Service Licent ee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory **Physician** /Medical Due to (or as a consequence of): TS Munia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown as been signed by 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No page CRI certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours arer death. To the Funeral Director: After Certification: 1/X Natural 5 Pending investigation 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10063/70 mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

RIZVI, MD Sinai

Ammtal of Bontimore 3 Registrar's Signature

VANJOSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (Eirst, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Sa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George 13912 Heather Stone Drive Bowie 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months Yrs Jan 10, 69 India Director 214-70-2052 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show t be notified at 10a, State 10b. County 1 X Yes 2 □ No Director MD Glenn Dale Prince George 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a 11801 Lilium Lane 20769 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Completed by 3 ☑ Widowed 4 ☐ Divorced Asian Indian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical than College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Heart of Hearth and Mental Heart of the marked of Bhiaubhai R. Desai Bhanuben Desai 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alka Desai /daughter 11801 Lilium Lane, Glenn Dale, Maryland 20769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 'Department of Important: If Ite any Injury or of 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Arundel Crematory Apr 22, 07 Odenton, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, M00773 1411 Annapolis Road, Odenton, Maryland 21113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fixal disease or condition resulting in death) **Physician** MATHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and I-trar Due to (or as a consequence of): the burialphysician Physician/Medical as 1 attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year in the past 12 months? Month Day 4□Pregnant at time of death ned by the a detached for 9□Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No aw 24a. Was an hast page certificate 1□ Yes Physician: director, 26. Place of Death (Check only one, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No 1 Inpatient 2 ER/Outpatient 3□ DQA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending

Box 68760 P.0. Records, Division or Vital After this uneral or Attending death the in by t the Hospital

altimore, Maryland 21215-0036

within 24 hours after death To the Funeral Director: filled Medical

10

State Registrar

29b. Signature and title of certifier

2007

investigation

6 Could not be determined

29c. License number

🖍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

person who completed cause of death (Item 23a) (Type, Pring 30. Name and address of

and manner stated

Sate 300 Amyolis

31. Date filed (Month, Day, Year) 7

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

32 Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fh e866 4-27-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2007 Alton Raymond Drolsum, Ed.D April 2Ž 5:50 P. M 4a. Fadlity Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death The Gilchrist Center Towson Baltimore County 8. Date of Birth (Month, Day, Year May 18, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 110 M 2□ F Months Days Hours Min 80 358-18-7468 Illinois Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2XXVo Maryland Carroll County Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4501 Babylon Road 21787 United States 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 □ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2Ã No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland State Board of Education Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milo James Drolsum James Milo Drolsum Ouida Melba Alexander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4501 Babylon Road Taneytown, Maryland 21787 Mrs. Helen N. Drolsum (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 Removal from State 1 ☑ Burial 2 ☐ Cremation Apr. 26, 2007 Owings Mills, Md. Garrison Forest, V.A. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road, Timonium, Maryland 21093 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, by complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) entho Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was a... autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation

Physiclan: The law requires that the death certificate be executed and burial-trar Division or Vital Records, P.O. Box 68760 attending physician the as peen certificate has this funeral After 1 Hospital or Attending death. after death Director:

Physician

/Medical

Examiner

Examiner Physician/Medical þ Completed Be Certification: To

Physician

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

1 Yes 2 No 27. Manner of Death

6 Could not be determined

28a. Date of Injury (Month, Day Year)

Injury 1 ☐ Yes 2 ☐ No

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

6701

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

32. Rafistrar's Signature APR 2

Ben

State

filled in by

Medical

within 24 hours at To the Funeral C

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ance.

Dickerson, Cotherine 4/25/01 11PM

Baltimore, Maryland 21215-0036

Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and campietely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

1 - State Registrar		Olalo of I	viai ylaila /		artment of H rtificate of I		···O··································	Reg. No.	007	354
Decedent's Name (F	irst, Middle, Last)		-				2. Date of De		V	3. Time of Death
Cat	therine	S. Di	ckersor	1			4	25	2007	11:00
4a. Facility Name (If no.	t institution, give s	treet and numb	er)		4b. City, Town, or)		County of Death	
Oak Cre	est Care	e Cent	er		Park	ville			Baltim	ore
5. Social Security Number 215-22-84		M 25.	Age (In yrs. last 95	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da 3/22/	1 9 1 2	9. Birthi Cou Ma	place (State or Fore ntry) ryland
Usual Residence of De 10a, State 10	cedent b. County		10c. City, To	wa or Lo	cation					10d. Inside City Lim
MD	Baltimo	ore	Too. Oily, 10		kville					1 ☐ Yes 🏋
10e. Street and Numbe					10f. Zip Code	21234		10g. Citize	en of What Cou	
11. Marital Status		2. Was Decede	nt Ever in U.S.	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S	pecify Yes or No)- 14	4. Race - Ameri Black, White,	
1 Never Married 3 Widowed 4	_	1 ☐ Yes 2 [If Yes, Give Year or Date	X No	1 -	1 □ Yes 2 No	Specify:	, ,	S	Canaihu.	hite
15.	. Decedent's Educ	ation completed)	16	Sa. Deced	dent's Usual Occupa	ation	kina	16b. Kind	d of Business/In	ndustry
Elementary/Seconda		College (1-4	or 5+)	life. L	kind of work done of DO NOT use retired)	KIIIG		D . L . ! 1	
	10				Manage	r			Retail	
17. Father's Name (Firs		1				18. Mother's Na	ne (First, Middle elen Kl			
Georg	ge Muel	Ter				n e	TEIL VI	erue	- T C T II	
19a. Informant's Name Dorothy					ng Address (Street a 302 High					
20a. Method of Disposit 1 XBurial 2 ☐C 4 ☐Donation 5 ☐	remation 3 Re	emoval from Sta	te ceme	of Disportery, crent arkw mete	sition (Name of natory or other place	a) Apr:	Date 28,		ation - City or To	
21. Signature of Funera	al Service License	8	Ce.		Name and Address	eral Cl	napel	8800	Harfo	ord Rd. MD 21234
231 Part 1. Enter the d	disease or malic	nations that saw	and the death D		Cremati		rices -			Z 1 Z 3 4 Approximate
snack, or neart ta	ulure. List only on	e cause on each	1 IIne.					11631,		Interval Between Onset and Death
Immediate Cause (Fina disease or condition resulting in death)	а. а.				inla a	unde	Γ			Week
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Sequentially list conditi	ione b	Dun to for	NOVI	7						years
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that initiated events resulting in death) Last	C.	Due to /es	as a co segueno	100	100					yars
		Due to (or	as a co-sequenc	e on):						
	d.	·								
IF FEMALE:										
23b. Was decedent pre in the past 12 mor 1 Yes 2 No 9 Unknown	nths?	1 Live birth	ne of pregnancy 2 Fetal dea at time of death		Ectopic pregnancy Other (specify)			23	3d. Date of delive Month	ery Day Year
Part II. Other significar	nt conditions cont	tributing to death	but not resulting	in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use	e contribute to t	he cause of death?
der	mente						10	Yes 2	No 3 ☐ Prot	bably 4 Unkne
							24a. Was	an	24h Wara auto	opsy findings availa
							auto	psy prmed?	prior to co death?	mpletion of cause
OF Was	1 - 2 - 2 - 2 1						1 ☐ Yes	2000	1 ☐ Yes	2 🗌 No
25. Was case referred to examiner?		ospital:	0		Othe	26. Place of Dea				
1 ☐ Yes 2 No		1 Unpa		Dutpatien	I JUDON	4 Landrsing F	ome 5 Resi			ly)
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1. Natural 5 2 Accident	-	28e. Place of building,	Injury - At home, etc. (Specify)	iarm, stre	7,		City or To	wii, Olato)		al Route Number,
1 Natural 5 2 Accident 3 Suicide 6 4 Homicide	Could not be determined	building,	etc. (Specify)			TO MANY DOCUMENTS			1 200000 00000	
1 Natural 5 2 Accident 3 Suicide 6 4 Homicide 6 29a. Certifier (Check only one) 2	Certifying Physi	building,	etc. (Specify) st of my knowled of examination	ue death	vestigation, in my op	oinion, death occu	and dual other	causals) a	nd in anner las s blace, and due to	rated
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Davoicion		Registrar 1. Decedent's Name (First, Midd	le Last)			ile oi	Death		12	Reg 2. Date of Death	g. No.		3. Time of Death
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,		Inner loop 695 and Pt 5. Social Security Number	IIaski Highway	7. Age (In yrs.	Loot hirth	- L	Rosedale If Under 1 Year	If Under	24 Hrs	8 Date of Birth	Baltimore		
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any	ľ	10a. State 10b. County		10c. Cit	y, Town o	or Locatio	on	-					10d. Inside City Limits
and show	5	Maryland Balt	imore	1	Midd	le R	iver						1 Yes 2 X No
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1 withi giene.	ΕĮ	17. Father's Name (First, Middle	Last)			Insp	ector -		Name (First Middle M	Ampor	LS	NOLCII
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmatic vent, the Medical Examiner must be notified at once.	1	20a. Method of Disposition 1 X Burial 2 Crematio	n 3 Removal f	rom State	cremato	ory or oth				Date			
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Bal permi Depa Impo injur	1	21. Signature of Funeral Service	Licensee			Ch:	ame and Address aries S. 24 Easte	Zeil	er 8	Son, i Balt	Inc. imore. M	D ·	21224
Physician	1	a. Pan I. Enter the disease, of failure. List only one cause	complications that	caused the dea	th. Do no								Approximate Interval Between Dnset and
/Medical Examiner	V.	Immediate cause (Final disease		juries									Death
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Box he death of the attent of the attent hed for us	P Nys		known g Unkr		. 145					22a Did to	hanna una anniri	uito to t	he cause of death?
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Divisior Hospital or Attend 24 hours after death. Funeral Director: stely filled in by the	۱ د	29a. Certifier	(0,000)	Major Ro			rod at the time, de	to and pla		<u> </u>			y, Towson, MD
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be deached for use as the built in the funeral director, page 2 should be deached for use as the built in the funeral director.	Medical	(Check only Certifying P	hysician: To the beaminer: On the basis	of examination									
F . Y E 0	E -	29b. Signature and title of certifi	and manner er	1 0			29c. License	e number			29d. Date signe	d (Mor	nth, Day, Year)
		XICH	N				0.C.I	M.E.			April 23, 20	07	
0		30. Name and address of person				1 Don	n Street, Balti	imere *	MD 242	201			
Sta	أ		Assistant Medi	egistrar's Signa	turo			intore, N	10 212				
Registra	ar	31. Date filed (Month, Day, Year)	2007 the	Que s	X	1034							

3551 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Maxmilan Lawrence Eder, Jr. 6:45 P 23, 2007 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Siani Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
April 27,1926
Baltimore, MD. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1X M 2 ☐ F 80 Director 219-18-6114 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County id 2 should be filed within 72 hours after death with the Marylan thin and Mental Hygiene. S7 is marked other than "natural; or liems 23a or 28a-f show traumatic event, the Markical Examines must be outlitted at 1 XYes 2 No Completed by Funeral Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21209 United States 2211 W. Rogers Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Q∆X'es 2 □ No If Yes, Give Year or Dates: W • W • 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: W.W.II 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver L.A. Benson 06 N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Barbara Ann Sipple Maxmilan A. Eder ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9108 Summer Park Drive Parkville, MD. criment of Health a criant: if item 27 is njury or other tra Mrs. Denise B. Kohlhepp (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem.Gard. 27,2007 Timonium,Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Jeffrey L. Gair 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A. mp my nny 8 lair 21093 232. Part. Enter the disease, or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Timonium, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACUTE ACUTE CARDIAC /Medical Due to (or as a consequence of) Examiner CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit ORON ARY Due to (or as a consequence of): DISCASE YFARS ARDIOVASCULAR Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABE -INSULIN DEPENDENT MEZLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown PRESSURE HYPLORIENSION. NORMAL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s 2 X No this certificate DEMENTIA WITH MEMORY LOSS 1 ☐ Yes 25. Was case referred to medical examiner? After this certification funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROGERS AVE-BALTIMORE ROBY M. D. - 2211 W.

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

APR 2 7 2007

Maryland 21215-0036

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Pages 1 and 2 should nent of Health and Men

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2 2 **Physician** 2.40AM 200 Ellis Kathleen /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GLEN BURNIE ANNE UNDE SALTIMORE WASHINGTON MEDICAL CENTER Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Day) | Min. | April 15 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday, **Funeral** 1 □ M 2 💢 F 54 270-54-2249 0H Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 3a or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Pasadena Anne Arundel Marvland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 750 G Street 21122 USA r than "natural", or items 23a the Medical Examiner must be Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify. Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the jonee. Household 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Latham Lewallen Marv Charles ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 750 G Street, Pasadena, MD 21122 John C. Ellis Jr. (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April Date 28 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland Glen Haven Cemetery 2007 21. Signature of Funeral Service Ligense 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Rosd, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the pear shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease or condition resulting in death) NAGGILAR ACCIDENT 1320 **Physician** CEPE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit that the death certificate be executed and Due to (or as a consequence of): Box 68760. physician Physician/Medical the IF FEMALE for use 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 45149 MI ess of person who comple cause of death (Item 23a) (Type, Print) 30. Name and add W fren bonne mi 20161 61 32. Signature 31. Date filed (Month, Day, Year, State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Ellis, Kathleen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 Robert Henry Evans /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HIZENS 7auredec ome orace UUrsing If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** 1XM 2□ F 093-05-7107 Director Aug. 1, 1909 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show TYTYes 2 □ No notified Directo Maryland Harford Havre de Grace 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 415 South Market Street 21078 23a USA 7 is marked other than "natural", or items 238 traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Associate_Engineer Defense Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Henry Clay Evans ဥ Mary Adele McCaughan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any injury or other trau once, Jo Ann E. Plaine / Daughter 1542 Bentley Circle, Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 4-26-07 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature of Funeral Service Licensee Kussell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) orona **Physician** 10 yrs /Medical Due to (or as a consider ence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine neumoung for use as the burial-tra-Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. detached 9 Unknown 9 Unknown ss been signed by the 2 should be detach€ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 s autopsy 2**X** No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide lor A within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 600 maus ulaculo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Houve De Grac MD 210'18 evalution Kammidy Milliam MD 1100

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

General D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23a, 25 per me, 8866, 144, 26/97 debth Reg. No. 1 - For State Registrar Amend Items 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** Year 3:18 PM 03 07 2007 <u>Charles P. Frank</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore City

9. Birthplace (State or Foreign Country) Baltimore Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ★M 2 ☐ F Yrs. Director 214-44-2459 65 10/14/1941 Maryland Usual Residence of Decedent a or 28a-f show t be notified at 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2X No Director MD Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a must death Funeral 12401 Hennessy Lane 21087 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "natural", or ite other traumatic event, the Medical Examine. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No \$ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Meat Packer Esskay Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Charles L. Frank Viola Comes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Theodora Frank (wife) 12401 Hennessy Lane - Kingsville, Maryland 21087 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdns.03/12/2007 | Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. assakn 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RIPPIR In RUBIO /Medical Due to (or as a consequence of): Cardiovascular Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a prinsequence of): Examine as the burial-transit and Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy be detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 2 Acute Ileocolitis; Rheumatic Valvulopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an has certificate Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ¥ Yes −2 XNo P 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Division Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death. 2 Accident in by the 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Burn AT2438946 MO March 7, 2007 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brown M.O Danielle Union Memorial Hospital, MD 31. Date filed (Month, Day, Year) APR 2 6 2007 32. Registrar's Signature State 13.

DHMH 17 Rev 1/2001

Registrar

Coast

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Physician 2:10 PM 24, 2007 4c. County of Death /Medical Agnes Ferguson
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 □ M 2 1 F Director 78 217-42-2144 Usual Residence of Deceder 04/26/1928 Scotland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" ~ " any injury or other traumatic evant." 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 TNo Director MD Howard Elkridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 14. Race - American Indian, Funeral 6502 Reile Dr 21075 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 2 3 Widowed 4 □ Divorced Caucasian Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ William McSorley Mary O'Donnel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather Rooney/Daughter 6502 Reile Dr. Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2☐Cremation 3 ☐Removal from State Apr 26 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland Chesapeake Crematory
22. Name and Address of Facility 2007 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the death. Cremation and Funeral Alternatives Maryland Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anterioscleratic Cardiovascular **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): Box 68760s Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cerebrovascular certificate Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 6 Other (Specify) HOSPICE ို this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death

(IN) atural

2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

Tousantown Blud

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's

	1	For State Registrar	State of M	arylan	d / Dep <i>Ce</i>	artment of F rtificate of	lealth an Death	d Mental H	ygien Reg. N	Break Self Self I	13	556
Dhysiolar		1. Decedent's Name (First, Middle,	Last)					2. Date of D		ay Year	3. Time o	of Death
Physiciar /Medica		Leroy Franklin						April	19	, 2007	9:20	PM ^M
Examine		4a. Facility Name (If not institution,	-			4b. City, Town, o		eath	4	lc. County of Deat		
		Stella Maris Ho				Timoni				Baltimo		
Funeral Director		5. Social Security Number 212-56-8900 Usual Residence of Decedent	5. Sex 7. Ag 1 X I M 2 □ F	6 (In yrs. 1	las <i>t birthday,</i> Yrs.	Months Days		Hrs. 8. Date of E Min. (Month, I May 13	Day, Yea	9. Birt 949	hplace (State untry)	or Foreign unk
iryland thow		10a. State 10b. County		10c. City	y, Town or L						10d. Inside 0	,
vith the Mar		10e. Street and Number	-		-	Baltimore 10f. Zip Code		unk	10g. C	Citizen of What Co	21	s 2∏No
s 23a o		100 Ambo Circle	10 W D11	5	0 140	N/ - D				USA	ricen Indian	
or items 23s miner must		11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Armed Forces? d 1 1 Yes 2 If Yes, Give		.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin; an, Mexican, Pi Specify:	? (Specify Yes or Nuerto Rican, etc.)	10-	14. Race - Ame Black, White	e, etc.	
ours Jraf", LExa	2	3 AWidowed 4 □ Divorced	Year or Dates:							Specify: b1		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	mbiere.	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or !	5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of d)	working	16b.	Kind of Business/	Industry	unl
Hed v Hygie her t		12 17. Father's Name (First, Middle, Li	0			janitora]		Name (First, Midd	la Maide	en Surnama)		
antal H ed oth	٥	Leroy Landis	,	*			_			on ourname)		
hould marke marke	ą.	19a, Informant's Name/Relationshi		L	19h Maili	ing Address (Street		ean Harri Rumal Boute Num		v or Town State 2	7in Codel	
rd 2 s Ith an 27 Is trau		Wanda Thomas/s				Fords La				21215	.ip 0000)	
os 1 ar of Hea Item :	1	20a. Method of Disposition		20b. P	lace of Disp	osition (Name of ematory or other place	ĭ	Date		Location - City or	Town, State	
Page nent c int: If		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☑ Other (Spe	3 ⊔Removal from State <i>ecify)</i> in state									
permit. Departn Importa any inju		21. Signature of Funeral Service Li Rona I d S		ector		2. Name and Addre tate Anat altimore.	•	rd 655 W	. Ва	ltimore	Street	
A 100 m	1	23a. Part1. Inter the disease, in conshock, in heart failure. List o	or phrations that caused	the death	h. Do not en	ter the mode of dyir	ng, such as car		arrest,		Approxima Interval Be	ate etween
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		IC CA	RDIOM	YOPATHY					Onset and	I Death
Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	a consequ	uence of):							
be executed ician and burial-transit	Yall	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):							
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ertific ling pl e as t		IF FEMALE:	00 1/									
requires that the death certificate een signed by the attending physical bould be detached for use as the total by Dhyeinian Madical	ysicially	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Feta	I death 3	□Ectopic pregnancy □ Other (specify) _	/			23d. Date of del Month	ivery Day	Year
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w requires that the d been signed by the should be detached	ם ב		<u> </u>					1	Yes	2 No 3 Pr	obably 4X	Unknown
sician: The law requirector, page 2 should	aldillo							— 24a. Wa au pe 1□ Yes	topsy rform <u>ed?</u>	prior to death?	atopsy findings completion of 2 ☐ No	
cian: ertific ector,		25. Was case referred to medical examiner?					26. Place of	Death (Check onl)				
ng Phy fter this ineral d	2	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Hospital: 1 Inpation	ıry	ER/Outpatie 28b. Time of Injury		4 LJ Nursir	ng Home 5 ☐ Re 28d. Describ		6 Other (Spe	cify) HOS	PICE
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu			Physician: To the best xaminer: On the basis of and manner st	f examina								•(s)
withir To th comp	INIC	29b. Signature and title of certifier)	7		29c. Licens	e number		29d. [Date signed (Mont		
		30. Name and address of person w	ho completed cause of c	leath (Item	n 23a) (Type	, Print)	9 / 6	.1				

State Registrar

DR • TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093
32. Registrar's Signature

DHMH 17 Rev 1/2001

LARIL 19, 2007 9:20 p.m. Baltimore, Maryland 21215-0036

APRIL 19, 2007

Division or Vital Records, P.O. Box 68760,

LEROY FRANKLIN

			For State Registrar	State of Mary		Certificate of		-	Reg. No.	07 10	3557
	Physici /Medic		Decedent's Name (First, Middle, Edna M	. Gentile				Month APRIL	Day	Veer	e of Death
	Examin		4a. Facility Name (If not institution,			4b. City, Town, o	or Location of Death		4c. Count		_
	Funeral Director		215-18-5965	6. Sex 7. Age (In	yrs. last birtho 83 yr	day) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 6 / 1 5	th ry, Year) 11923	9. Birthplace (Sta Country) Maryla	te or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town o	r Location				10d. Inside	e City Limits
	e Mary a-f sh tified a	ctor	MD Bal	timore	Par	kville				1 🗆 \	∕es 2 X No
47	th with th 23a or 28 ust be no	Funeral Director	10e. Street and Number 9103 Summer	Park Dr.		10f. Zip Code	21234		10g. Citizen of US	What Country?	
-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U.S.	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		ecify Yes or No Rican, etc.)	Bla	ce - American Indian ick, White, etc. fy: White	,
16 215-0	thin 72 h e. an "natu Medicai	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or 5+)	16a. D	ecedent's Usual Occu Give kind of work done ife. DO NOT use retire	pation during most of working ed)	ing	Ва	Business/Industry Itimore	
12	iled wil Hygien ther th		12 17. Father's Name (<i>First, Middle, L</i>	act)		cook	18. Mother's Name	/Firet Middle		y School	<u>s</u>
GENT!	ild be filenta! Fred of	To Be	John P. Cot					•	. Dels:	,	
ary (2 shou and N is mar		19a. Informant's Name/Relationshi		- 1	Mailing Address (Street			-		
	1 and Health tem 27		Mary Patterso	20		103 Summ		Date		Le, MD 2 - City or Town, State	
Baltimore,	t. Pages tment of tant: If it ijury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecity)	Par Ceme	isposition (Name of crematory of other pla KWOOD tery	200	1	Park	ville, M	D
Bal	permit Depar Impor any In		21. Signature of Funeral Service	io dee		22. Name and Addre Evans Fu: & Cremat.	neral Ch ion Serv	apel ices	8800 Parkv	Harfor	d Rd. 21234
			23a. Part1. Enter the disease, or o	complications that caused the only one cause on each line.	death. Do not	t enter the mode of dyi	ing, such as cardiac o	or respiratory a	rrest,	Approxi Interval Onset a	mate Between nd Death
	/Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cor	nsequence of)						
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	nsequence of)	:					
10	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· HTN							
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0.	at the dea by the a tached fo	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death	5 ☐ Other (specify) _				onn buy	100
rds, F	quires than signed ald be de	by	Part II. Other significant condition	ns contributing to death but not	t resulting in th	ne underlying cause gi	ven in Part I.			atribute to the cause 3 ☐ Probably 4	_
Division or Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Completed						24a. Was auto perfo 1□ Yes	ormed?_	Were autopsy findir prior to completion death? 1 □ Yes 2 □ No	igs available of cause of
Vit.	/siclan s certifi lirector	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient	2 □ ER/Outpa	atient 3 DOA Oti	26. Place of Death her: 4 ☐ Nursing Ho			her (Specify)	
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	Λ		30. Name and address of person w	who completed cause of death	(Item 23a) (Ty	/pe, Print)	0000		04.	24-200 imore, MD.	>/
	, /		ir. Alireza Sha	abani- Ardali 32. Registrar's S	900	D FRANK	din Squa	HREIDA	BALT	imore, MD.	2123
	Sta Registi		31. Date filed (Month, Day, Year)	2007 / 2007	M	Coast!					
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Physic	ian_	Decedent's Name (First, Middle, I	Last)							2. Date of I	Death Day	Year	3. Time o	f Death
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Exami	ner	4a. Facility Name (If not institution, g		iber)		4b. City, T			of Death			County of Death		
Funeral		Friends Nursing 5. Social Security Number 6.		7. Age (In yrs.	last birthday	Sandy	-	ring If Under 2	24 Hrs.	8. Date of B		ntgomery	nlace (State	or Foreig
Director		064-05-2226 Usual Residence of Decedent	1□M 2 X F		39 Yrs.		Days	Hours	Min.	8. Date of 8 (Month, 1-21-	1918	Cot	York	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death O'7 **Physician** Month 0520M APR н. Godfrev /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CARE BALTIMORE HEALTH ST. AGNES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 ⋤ F Director 218-18-3567 89 August 11, 1918 N. Carolina Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 6383 Loudon Ave USA 21075 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes Sp No Specify: þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Counselor Local Govt permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygn Important: If item 27 is marked any injury or other to once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chan C. Rogers Bertha ၉ I. Rogers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7005 Clubhouse Cir., New Market, MD 21774 Richard Godfrey- son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 4/25/2007 Elkridge, MD 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP, INC. 21. Signature of Funeral Service Licensee Myr 7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LOSTRIDIUM DIFFICILE COLITIS **Physician** disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of: that the death certificate be executed that initiated events resulting in death) Last nding physician and use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by PLEURAL EFFUSIONS BILATERAL 1 ☐ Yes 2 No 3 Probably 4 Unknown MALNUTRITION 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page ANEMIA 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation Injury ours after death.

neral Director: A
y filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054257 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) $M_{\star} S H AR M A , 900 CA T i$ CATON AV. BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 200-**Physician** DEMETRIUS 1300 M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A BOITMOIC If Under 1 Year | If Under 24 Hrs Hospita chno Hookins 8. Date of Birth (Month, Day, Jan. 01 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdav **Funeral** Months Days Hours 1 ☑ M 2 ☐ F Jan. 1998 428-83-9234 MS Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a State 10c. City, Town or Location 1 Yes 2 YNC Director NC Durham Durham 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 5 Whistler Woods Court 27703 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: **Black** Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Gleen Demetrius Hall Nicole Zaneta Aubert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5 Whistler Woods Court, Durham, NC 27703 Zaneta A. Hall (mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 28 Oak Grove Cemetery Durham, NC 27713 21. Signature of Funeral Service License 22. Name and Address of Facility Name and Address of Facility Stallings Fun 3111 Mountain Road, Pasadena, Funeral Home, P.A. ena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kenal Fallure **Physician** month disease or condition resulting in death) /Medical Due to (or as a consequence of) Wemia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner host disease 3 months burial-trar Due to (or as a consequence of) ed by the attending physician detached for use as the burial Division or Vital Records, P.O. Box 68760, as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Anter this certificate has been signed by a funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ noleukodustroph 2 No 3 Probably 4 WUnknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed/ 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥ No Date of Injury (Month, Day Year) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

3

State

30. Name and address of persor

31. Date filed (Month, Day, Year)

APR 27

2007

N. Wolf St. Batt. MD

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 27,28a-I per me,2866.04/26/07dhb Reg. No. 1356 1 - For State Registrar 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** Angela R. Harris 2007 23:17 03 21 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death **Examiner** N/A Hospital Samaritan Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** 213.54 3356 Months Days Hours Min. 1 ☐ M 2 🔀 F 58 Yrs MD 29/1948 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Battimore 1 ☐ Yes 2 No Baltimore Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "--- any injury or other traumes". 21234 36 Dowling Circle USA Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of MID Dept. of College (1-4or 5+) Elementary/Secondary (0-12) Clerk Social services 12tharade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Randolph ouise Dare Nomas ဂ္ 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harris/Husband Balto. MD 21234 Charles E. Circle Apt. T-2 36 Dowling 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 04.07.07 Windsor Mill, MD Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaugur C. Greene Puneral Sove 21. Signature of Funeral Service Licensee W. lun Road Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pelmonory **Physician** Embolism disease or condition resulting in death) /Medical Due to (or as a consequ Examiner Retroextoned Due to (or as a consequence of): Hematomo CERTIFICATION ADSTROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🛣 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 □ No Hypertension 24a. Was an autopsy performed? 1∰¥es 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To after death.

I Director: After this d in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Probable femoral artery punctured during cardiac

1. Location (Street and Number Cardiac City or Town, State) 5 Pending investigation 1 ☐ Yes 2 XNo 03/19/2007 Unknown M 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 2000 W. Baltimore St., Baltimore **Hospital** within 24 hours a To the Funeral I the Hospital CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Line CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

Line CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 29b. Signature and title of cortific 29c. License number 29d. Date signed (Month, Day, Year) 061 H0059388 07 Lorman 5 Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) Lock Rova Blod , Baltimore MO 21239 David Weisman 5601 31. Date filed (Month, Day, Year) 32 Segistrar's Signature State Registrar APR 10 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3562 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ADril Day 26 **Physician** 2007 Bernadine 10:35 AM J. Haak /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mariner Health of Glen Burnie Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral Year) 918 88 064-14-7726 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Anne Arundel Marvland Pasadena 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 301 Kentucky Ave. 21122 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard Hoffert Josephine ၟႍ Croniser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Janet Manikas (Daughter)</u> 301 Kentucky Ave. Pasadena, Md. 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Department of F Important: If Ite any injury or ot once, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 4/27/07 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify 22. Name and Address of Facility Stallings Funeral Home PA 21. Signature of Funeral Service Lice 3111 Mountain Rd. Pasadena, Maryland 21122 23a. Part1. Inter the dise v.e, or complications that c. used the shock, or heart failure. List only one cause on e ch line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** VASCULAI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner STIZOICE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> HYPERTHYIZOID 1 Yes 2 No 3 Probably 4 Unknown Completed FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 25. Was case referred to medical examiner? 26. Place of Death (Check only one,

Be

2

Certification:

Medical

State Registrar 1 Yes 2 No

5 Pending investigation

6 ☐ Could not be

27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

31. Date filed (Month)

29b. Signature and title of

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

DHMH 17 Rev 1/2001

28c. Injury at Work?

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 🗌 Yes

2 □ No

D000 Z519

Other: 4 Aurising Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day Year)

and manner stated

32 degistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3563 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death APRIL 24, 2007 **Physician** 5:50a M DELORES JEAN HOWELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 23 N. MONASTERY AVE. BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 9-28-1 933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F VIRGINIA 223-40-5539 74 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 →Yes 2 No Director N/A BALTIMORE MD. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21229 USA 23 N. MONASTERY AVE. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) -12-College (1-4or 5+) HOME SERVICES DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHESTER McDOWNEY DELORES CARTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDREW HOWELL (HUSBAND) 23 N. MONASTERY AVE. BALTIMORE, MARYLAND 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 □Removal from State 4-28-2007 MARYLAND NATIONAL LAUREL. MARYLAND 4 ☐ Donation / 5 ☐ Other (Epecify) runeral Service Ligens D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. NAREAM 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 shock or heart failu Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC BREAST CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.0. has been signed by the second 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe page death? 1 ☐ Yes 1□ Yes 2 🗆 No 2 No 25. Was case referred to medical examiner? funeral director. To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide

Hospital or Attending Physician: Director within 24 hours a

To the Funeral I

completely filled

> State Registrar

Medical

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRISTINA TRUICA, MD SINAI HOSPITAL 2401 W. BELVEDERE AVE. BALTIMORE, MARYLAND 31. Date filed (Month, Day, Year) APR 2 7 2007

32. Registrar's Signature & Speck

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License литber

D0062254

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

4/24/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

13564

		1	For State Registrar	State Of Ivial	ryland / Depa <i>Cer</i>	tificate of L			g. No.	, 3 3 3 .
1	D		1. Decedent's Name (First, Middle, Last)	HEAP	C			2. Date of Death Month_	Day Yea	3. Time of Death
	Physicia /Medic	al	Barry	- 1	3			April 2	3, 2007 Year	3:20 A M
	Examin		4a. Facility Name (If not institution, give str				Location of Death		4c. County of De	
Į.			Catonsville Commons 5. Social Security Number 6. Sex		(In yrs. last birthday)	Catons If Under 1 Year	SVILLE If Under 24 Hrs.	8. Date of Birth (Month, Day,	Baltimo 9.8	TE lirthplace (State or Foreign Country)
L	Funeral Director		218-09-2517 ¹ X ^N	4 2 D E	92 Yrs.	Months Days	Hours Min.	May 29,	1914 M	aryland
	iand in the stand	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary I sh	ţ	Maryland Baltimore		Caton	sville				1 ☐ Yes 2 ☐ No
	th the	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	23a c	rai	6206 Frederick Road				21228		USA	India-
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event. The Medical Evantiner must be notified at once.	l by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	. Was Decedent Evanued Forces? 1 ☐ Yes 2 ▼ Note of Yes, Give Year or Dates:	ver in U.S. 13. \		ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Hace - Ar Black, Wi Specify:	nerican Indian, hite, etc. White
2 2	72 hc	etec	15. Decedent's Educa (Specify only highest grade of	ition completed)	16a. Deced	dent's Usual Occup kind of work done	ation during most of work d)	ing	6b. Kind of Busines	ss/Industry
7	1.2 should be filed within h and Mental Hygiene. 7 is marked other than " raumatic event. The Mer	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		1)		Retail	Sales
7	filed v Hygie Ither I		17. Father's Name (First, Middle, Last)		Mana	ger	18. Mother's Nam	e (First, Middle, M		
an	ld be ental ked o	To Be	Frank G. Heaps				Anna Mc	Clelland		
Maryland	shou ind M i mar umat	-	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailir	ng Address (Street	and Number or Rui	al Route Number,	City or Town, State	e, Zip Code)
ž	alth a		Patricia Brown / Da	ughter		_			, Marylan	
altimore,	as 1 a of He of Hem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other place			20c. Location - City	
Ĕ	Page nent a	131	'4 □Donation 5 □ Other (Specify)	IIIOVAI IIOIII State	Meadowrid	dge Mem.			lkridge,	
at	permit. Departr Imports any inji		21 Signature of Funeral Service License	Ling		2. Name and Addre 1107 Wilk			uneral Ho more. Man	ome, Inc.
	Physician		23a. Part1: Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused to cause on each line	the death. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):	-				V- 1
Н	Examiner		Sequentially list conditions, b.		\mathcal{C}	AD				Ms.
(sit ad	ine	Sequentially list conditions, if any, leading to immediate cause Et terms anying Cause (Disease or injury that initiated events c.	Due to (or as a	consequence of):					
14	and I-tran	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):					
. 68760,	tificate be executed ig physician and as the burial-transit	edical E	d.							
			IF FEMALE:	a li una cutacana d	of exceptions			121/22	224 Date of	delivery
O. Box	w requires that the death certift been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	Fetal death 3	⊒Ectopic pregnanc □ Other (s <i>pecify)</i> _	у		23d. Date of Month	Day Year
۵.	requires that the een signed by th nould be detache	Y Ph	Part II. Other significant conditions cont	ribuling to death bu	t not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did tot	pacco use contribut	e to the cause of death?
ds	uires n sign	d by			of D			1 □ Ye	es 2 No 3	Probably 4 Winknown
of Vital Records,	e far has je 2	Completed						24a. Was a autops perform	ned? prior death	
<u>ta</u>	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?		-		26. Place Dea	th Check onl on	е	
<u>~</u>	Physician: this certific	5	1 ☐ Yes 2 ☑ No	spital: 1 🗌 Inpatier		nt 3 DOA	- Control of Marie		ence 6 Other (S	Specify)
0			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time o Injury	Wo	rk?	28d. Describe no	ow injury occurred	
<u>S</u>	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	One Place of Injur	ry - At home, farm, st]Yes 2□No	28f. Location (SI	reet and Number of	r Rural Route Number,
Division	after of Direction by	Certification;	4 Homicide determined	building, etc	(Specify)	reet, ractory, office		City or Town		
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	edical C	29a. Certifier (Check only one)	ician: To the best of er: On the basis of and manner sta	of my knowledge, deal examination and/or in led.	th occurred at the ti	ime, date and place opinion, death occu	, and due to the c rred at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
×	To the within To the comple	Med	29b. Signature and title of certifier	~0,		29c. Licen:	se number	_ 2	9d. Date signed (M	onth, Day, Year)
	Ve		30. Name and address of person who con	npleted cause of de	eath (Item 23a) (Type	Print) Veder	ick Ro.	Catem	yn'll, 1	onth, Day, Year) 25, 2007
	St: Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 7 2007	32. Registra	r's Signature	K)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Crivial yield A Department of Treatmand Weritaining		eg. No.	200	1 1336
Physicia Iedical Examir	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month April 26, 2	th	Year	3. Time of Death 0610 hrs
nemcai Examin		Wendell Allen Hurley 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death			nty of Death	00101115
		202 Village Drive Church Hill			n Anne's	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	⊸ i	rth(MM/DD/YY	Foreign	hplace (State or
Director		217-70-6962 1XM 2F 47 Yrs.	Nov 1	5, 1959) Cou	^{intry)} Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
≥ .	5	MD Queen Anne's Church Hill				1 X Yes 2 No
Maryl 28a-f	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of	What Coun	try?
ith the 23a on notifie		202 Village Drive 21623 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sn		U.S.A		Latina Diant
eath with the Maryland items 23a or 28a-f show ust be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto			ace - Ameno hite, etc.	can Indian, Black,
after d	된	1 X Yes 2 No 3 Widowed 4 X Divorced of Pate: 1978-83 1 Yes 2 X No specify:		Specif	√ Whit	e
hours		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w		16b. Kind of	Business/Ir	ndustry
36 hin 72 e. than	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Printer		Commo	rcial	Printing
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	턍	17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle,			Trincing
121 d be fi fental l narked	8	Ronald Wendell Hurley Georgia				
ID 2 2 shoul and N 27 is m	٩	19a. Informant's Name/Relationship (Type, Print) Georgianna Hurley /mother 19b. Mailing Address (Street and Number or F				Zip Code)
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location		Town, State
MOP Pages sent of ant: H		1 Bullat 2 Gerhation 3 Kemova nom state	1, 07	Dorse	ey, M	aryland
Salti ermit. epartm nports njury o	Ī	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral				
Physician	4	M00773 313 Talbott Ave. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	Laurel,	Maryla		0707-4389 Approximate Interval
'Medical		failure. List only one cause on each line.	Copilatory an	000, 011000, 01		Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Acute correct through is Due to (or as a consequence of):				
	ا ي	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
uted d ansit		events resulting in death) Last Due to (or as a consequence of): d.				
760, froate be executed physician and the burial - transit	Medical	X UNPENDED AMENDED 27, perME, g867 5/7/07 TT				
760, ficate be g physici the buri	Š	IF FEMALE: 23c. If yes, outcome of pregnancy			e of delivery	
Box 68 e death certif the attending ed for use as	Sar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	incy	Month	1 D	ay Year
P.O. Box 68: that the death certifi ned by the attending detached for use as i	Physician/	1 Yes 2 No 9 Unknown g Unknown	I sa latin			
P.O.	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		_		the cause of death? ably 4 🗸 Unknown
ords, w require s been sig	Completed		24a. Was	an 24	b. Were aut	topsy findings available
e law re has t	힐			rmed?	death?	ompletion of cause of
of Vital Records, fing Physician: The law require After this certificate has been siteneral director, page 2 should be	0	25. Was case referred to medical 26.Place of Death (Check	1 Yes	2NO	1 ✓ Ye	s 2 No
Vit;	2 P	1 6 16 2 100	ng Home 5	Residence 6		: Scene
n of Iding Pl		27, Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe	how injury occ	curred	
Division tal or Attendi rs after death. al Director: A	icat	2 Accident Investigation 28e Place of Injury - At home farm street, factory office building etc.	28f. Location (Street and Nui	mber or Ru	ral Route Number, City
Div pital or ours afte cral Dir	Certification:	Suicide 6 Could not be determined (Specify)	or Town,	State)		0
		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a				
To t With To t	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number				nth, Day, Year)
		O.C.M.E.		April 26,		
	ŀ	30. Name and address of person who completed cause of death (Item 23a)		1		
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21.	201			
Sta Registr	_	31. Date filed (Month, Day, Year) APR 2 7 2007 32 Registrar's Signature				

Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

requires that the death certificate be executed or Attending Physician: 24 hours after death Funeral Director: filled in by Hospital within 2.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number d title of certifier

29b. Signature an

31. Date filed (Month, Day,

29d. Date signed (Month, Day, Year) 739

007

30. Numer of eddress of person who completed cause of death (Item 23a) (Type, Print)

STREET BALTIMON E. 7-7 S. GREENE

State Registrar

Medical



07-03136 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jowallere Hagerman State of Maryland / Department of Health and Mental Hygiene 1- For State 2007 Certificate of Death Registrar Decedent's Name (First, Middle,Last) Reg. No. Physician/ 2. Date of Death Medical Examiner Time of Death JO WALLENE HAGERMAN Month Day April 23, 2007 2348 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1231 Chipper DRive Edgewood Harford uneral 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) Director 9. Birthplace (State or Months Days 213-68-8854 Hours Min 2 **X** F Foreign Country) ĺМ 4 a 9-27-1957 Usual Residence of Decedent MD 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD HARFORD Director **EDGEWOOD** 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 1231 CHIPPER DRIVE 10g. Citizen of What Country? 21040 U.S.A. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1 Never Married 14. Race - American Indian, Black. Armed Forces? 2 White, etc. Yes 2 X No traumatic event, the Medical Examiner 4 XDivorced "natural", If Yes, Give Yee \$ 1 Yes 2 X No specify: Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) ges 1 and 2 should be filed within 72 l of Health and Mental Hygiene. Complet Baltimore, MD 21215-0036 If item 27 is marked other than 12 2 MEDICAL BILLING JOHN HOPKINS 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be FRED HARE NORMA ٥ 19a. Informant's Name/Relationship (Type, Print) (RAINES) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTOPHER KERNTKE/SON 8612 OAK ROAD BALTIMORE, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery or other Burial 2 X Cremation 3 20c. Location - City or Town, State Removal from State crematory or other place) Department o Donation 5 Other Specify. METRO 4-27-07 CREMATORY CATONSVILLE, 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician 21237 /Medical Approximate Interval Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease Between Onset and Examiner Death or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit death certificate be executed Physician/Medical attending physician for use as the burial UNPENDED X AMENDED PERME, g867, 5/19/07 TT IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23d. Date of delivery past 12 months? Live hirth Fetal death 3 Ectopic pregnancy Pregnant at time of Day Year Other (Specify) 1 Yes 2 V No 9 Unknown death Unknown 9 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Alcoholism Records, Completed 1 Yes 2 No 3 Probably 4 V Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific Yes 2 1 V Yes 2 No 25. Was case referred to medical of Vital Be 26.Place of Death (Check only one) examiner? Hospital: 1 Yes Other₄ Inpatient ER/Outpatient DOA Nursing Home 5 Residence 6 ✔ Other: Scene 27. Manner of Death 28a. Date of Injury (Month, Day, Year Certification: 28b. Time of Injury 28c. Injury at Work? Division 28d. Describe how injury occurred 1 V Natura the Pending Yes 2 No 2 Accident filled in by Investigation 3 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City determined or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29h Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 24, 2007

State

Registra

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

gistrar's Signature

ORIGINAL

Laron Locke MD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year 1920 PM Jackson. **Physician** Pamela April 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Columbia Howard County General Howard If Under 1 Year | If Under 24 Hrs. 7. Age (În yrs. last birthday, 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Min. Hours Months 1 ☐ M 2 🔀 F 25 Director 08/31/1981 342-70-3408 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MD Clarksville Howard 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number USA 21029 Funeral 12004 Broad Meadow Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2.15 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) N/A Elementary/Secondary (0-12) College (1-4or 5+) Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Velda Haynie Raymond Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Raymond Jackson/Father 12004 Broad Meadow Lane Clarksville, MD 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Apr 26 1. Burial 2 ☐ Cremation 3 Removal from State Arbutus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 Arbutus Memorial Gardens 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MANA Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Kenal adure months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Shock Sequentially list conditions, if any, leading to firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit cellulitis Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death.

I Director: Ald in by the fur 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral C 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

Registrar

State

atuexent

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

little

10724

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23a, 25 per me, g866, 04/26/07 llbb.

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 23 **Physician** 6.16 PM 5. 2007 Jenkuns ebruary AVID /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** a nes Timore If Under 1 Year | If Under 24 Hrs. 5. Social Security Numb 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F Yrs. 10-31-1959 8602 **Director** 267-63mit Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 28a-f show a 1 ☐ Yes 2 No be notified Director MD Ellicott 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Ri "natural", or Items 23a ver lerrace Ct. 21043 Examiner must USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced Black Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs. CAShier Jul ant permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if item 27 Is marked other: or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be lterbert Jenkins tarland ဥ atherine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City Felicia Jenkins River Terrace MD 21043 Wite Method of Disposition

1 ■ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Injury (3-3-2001 Baltimore, Cemeter 4 Donation 5 Dother (Specify) Abrutus 22. Name and Address of Facility reene Funeral Services Naughn C. Greene Funeral Services 5151 Baltimore Nati Pike, Balto., m) 21. Signature of Funeral Service Licensee C. Greene augun mi) 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Hypertensive Cardiovascular Disease Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hour disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner po chu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last quentially list conditions CENTERINTON APPROVED BY MEDICAL EXAMINER WAY Due to (or as a consequence of) Examine Due to (or as a con Box 68760. attending physician Physician/Medical the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the a detached f 9∏Unknown Records, P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 End Stage Renal Disease 1 Yes 2 No 3 Probably 4 Nonknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1

✓ Yes 2 □ No 24a. Was an has autopsy performed? Yes 2 \(\square\) No certificate 1 Yes Division or Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 9 Hospital or Attendl 24 hours after death. 9 Funeral Director: A death. 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To the within 2 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 156226 8 9 leted cause of death (Item 23a) (Type, Print) 900 Caton Ave Baltimore 0

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 6 2007

NIXN3

32. Registrar's Signature

			For	Stat	e of Maryla	and / Dep	artmer	t of He	ealth a	nd M	ental H	ygier	ie	, ;	0.7	-7 O
		_	- State Registrar			Ce	rtificat	e of D	eath			Reg. N	10 U U Z		00	10
	Physicia	an	1. Decedent's Name (First, Middle								2. Date of D Month		ay Year		ime of De	
	/Medic	al	Carolyn H. Jo		nd number)		4h City	Town, or L	ocation of		April		2007 Ic. County of Dea		:45	AM'"
	Examin	er	1810 Wilson H				1	altin		Dealli		- 1	Baltimor			
Ŧ	Funeral		5. Social Security Number	6. Sex		rs. last birthday,		1 Year	If Under 2	24 Hrs. Min.	8. Date of B	irth	9 Bir		State or F	oreign
	Director		048-16-9130	1□M 2X	2F 9	1 Yrs.	Months	Days	nours		Jan 7,			• •	usett	:s
	and W	-	Usual Residence of Decedent 10a. State 10b. County	,	10c.	City, Town or L	ocation							10d. In:	side City I	Limits
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	death with the Maryland ms 23e or 28a-f ehow r must be notified at	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. (Citizen of What C	ountry?		
	th witi	a D	1810 Wilson Po	int Roa	d			21	220				USA			
	ems ems	iner	11. Marital Status	12. Was	Decedent Ever i	n U.S. 13.	Was Dece	dent of His	panic Orig , Mexican,	gin? (Spe , Puerto l	cify Yes or h Rican, etc.)	10-	14. Race - Ame Black, Whi		dian,	
20	s afte	by Fu	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	l If Ye	Yes 2 MNo s, Give		1 🗆 Yes		Specify:				Specify:whi			
215-0036	tural	ed b		nt's Education	r or Dates:	16a. Dece	dent's Usu	al Occupat	ion			16b.	Kind of Business			
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yland	be file tal Hy d oth	Be	17. Father's Name (First, Middle,						18. Mother	r's Name	(First, Midd	le, Maid	en <i>Sumam</i> e)			
<u> </u>	Men Men Marke Marke	2	Charles M. He		-1						bley 1					
Mar	d 2 st th and 7 le n traun	e l	19a. Informant's Name/Relation:										y or Town, State,			
<u>စ</u> ်	Heal Heal tem 2		Julie Gaynor/d 20a. Method of Disposition	aughter		b. Place of Disp	osition (Na.	ne of			d Balt		Location - City or			_
Ē	Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 4 📆 Donation 5 ☐ Other (5		from State	cemetery, cre	matory or t	tner place,								
Baitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other then "natural; or items 23e or 28e-f show any injury or other traumatic event, it a Medical Examinar must be notified at once.	1	21. Signature or Euneral Service Ronal		Direct	or c ²	2. Name a	d Address	of Facility	y 1	655 11	D.	ltimore	a .		
ñ	20 5 3		Janny	7/19/1	Direct	Ba	altimo	ore, l	my Bo	oard 21201	W CCO	. ва	iltimore	Stre	eet	
			23a. Part 1. Enter the disease of shock, or heart failure. Lis	r complications t only one cause	that caused the c	leath. Do not er	iter the mod	le of dying,	, such as o	cardiac o	r respiratory	arrest,		Inter	oximate val Betwe	
j l	Physician		Immediate Cause (Final disease or condition	a .	Lung	i Ca	nces							-	et and Dea	
	/Medical Examiner		resulting in death)	Di	ue to (or as a con											
		er	Sequentially list conditions,	b	ue to (or as a non	Sewaterion (A)								ļ		
	ned insit															
J.	be executed sicien and burial-transit	Examin	resulting in death) Last	C. DI	ue to (or as a con	sequence of):										
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9	The law requires that the death certifica lie hes been signed by the attending ph bege 2 should be detached for use as th	Med	IF FEMALE:									-				
X Q	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	10	es, outcome of pre Live birth 2 1	Fetal death 3	□Ectopic p						23d. Date of de Month	elivery Day	Yea	ar
<u>.</u>	he de	Physician/Med	1 ☐ Yes 2 X No 9 ☐ Unknown	1 Yes 2 No 4 Pregnant at time or death 5 Other (specify)								World Day Foat				
1	that the by detact		Part II. Other significant condit	ions contribution	g to death but not	resulting in the	underlying	ause giver	n in Part I.		23e. Die	d tobacc	acco use contribute to the cause of death?			
Sp	w requires that been signed b should be det	d by	Liver 1.	netastas	ses						10	1 Yes 2 No 3 Probably 4 Unknown				
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<u>ra</u>	stan: artitice ctor, p	Be C	25. Was case referred to medical examiner?	al							(Check onl	y one)				
<u>o</u>	Physic this corral dire	၉	1 ☐ Yes 2 No	Hospital:	1 ☐ Inpatient Date of Injury (Month, Day Yea		All Nursing Home 3 Hesidence 6 ADDITION (Specify)						ecify) S	ton'.		
ב	ding P. h. After I	ion:	27. Manner of Death 1 Natural 5 ☐ Pendi	r) 28b. Time Injury	njury Work?					28d. Describe how injury occurred						
Division	death death ctor: y the	ficat	3 Suicide 6 Could	tigation I not be mined 28e.	Place of Injury -	At home, farm, s	M treet, factor		63 2 🗀 1		28f. Location	(Street	and Number or F	Rural Rou	te Numbe	er.
2	efter Dire d in b	Certification;	4 Homicide	miled	building, etc. (Sp	ecify)		,,			City or 1					
	To the Hospitel or Attending Physician: within 24 hours elter death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edicai C	29a. Certifier 1 Certify	ng Physician:	To the best of my the basis of exar	knowledge, dea	th occurred	at the time	e, date and	d place,	and due to the	e cause	e(s) and manner a	is stated.	called(c)	
	the hin 24 the F	Medi	one) 29b. Signature and title of certifi													
١	So T will		250. Signature and the or certifi	1/10	1.11	In	28	1) >	V. 3.5	-6		290.	Const 1	/_ >	(m)	
•			30. Name and address of person	who commend	d cause of death	(Item 23a) (Tur	Print)		, 5 5	E/			1.00	5, 4	00/	
			Wm Waterf	eld 9	d cause of death	rankli	5	. Dr	. 5	+. 3	200	Ba	1to. m	D .	212	37
	Sta		31. Date filed (Month, Day, Year	207	32. Registrar's S	ignature	20						, , ,			
	Regist	ar	APR 2 7 20	007	ser so	Maria										

			1 - For State Registrar	State	of Marylar	-	artment of H		d Mental Hy	giene	07 357
	Discosia:		1. Decedent's Name (First, Midd.	le, Last)					2. Date of De Month	ath Day	3. Time of Death
	Physici /Medio		Roy Carl Jens	sen					April		007 12:14 A M
	Examir		4a. Facility Name (If not institution	-	ım <i>ber)</i>		4b. City, Town, or	Location of C	Death	4c. County	of Death
			Joseph Richey	y Hospice			Baltin	nore			
	Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.	**	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da	v. Year)	Birthplace (State or Foreign Country)
	Director		214-40-5809	IAM 207	76	Yrs.			March	6, 1931	Massachusetts
	pue ≱_		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Aaryi Peho	5	Maryland Baltin								1 ☐ Yes 2X No
	28a-	ect	10e. Street and Number	iore		Caton	sville			10g. Citizen of V	Mhat Country?
	With With	ă								rog. Citizen on	what Country?
	98 23	era	21 # I Montros	se Manor C	court	C 12.1	21228		? (Specify Yes or No	USA	e - American Indian.
	iten iten	S	1 Never Married 2 Mar	Armed F	orces?		f Yes, specify Cuba	n, Mexican, P	uerto Rican, etc.)		ck, White, etc.
9	urs al	by Funeral Director	3 XWidowed 4 ☐ Divorced	If Yas G	ive		1☐ Yes 2☑ No	Specify:		Specify	w White
ŏ	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ehow fra Mazical Exercit er mat be notified at	ted		it's Education			ient's Usual Occupa			16b. Kind of B	usiness/Industry
2	nin 7	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed)	1-4or 5+)	(Give	kind of work done of OO NOT use retired,	luring most of)	working		
7	d will	Eo	Elementary/obcortoary (0-12)	5+	1-401 5+)		Editor			NS	SA
פ	oth oth	BeC	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Middle	Maiden Suman	ne)
<u>a</u>	Aente Aente rked fice	ToE	Carl Jensen					Marie	Mortenser	1	
Maryland 21215-0036	and !		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Street a	ind Number o	or Rural Route Numb	er, City or Town,	State, Zip Code)
	and saith n 27		C. Claire Jense	n Da	ughter	239	South Eas	t Aven	ue. Balti	more. Ma	cryland 21224
ore	of He		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other place	9)	Date	20c. Location -	City or Town, State
Ĕ	Pag nent int: il		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (S		State	_	rematory		25/2007	Catonsv	ille, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. The notion of the Transfer of the Transfer Transf		21. Signature of Funeral Service	Licensee		22	. Name and Addres	s of FacilityS	terling A	shton So	chwab Witzke
m	40 F 8 9		Clebecs	10	<	- F	uneral Ho 630 Edmon	me of	Catonsvil	le, Inc.	e. MD 21228
			23a. Part1. Enter he disease, shock, or heart failure.	complications that	aused the deat	h. Do not ent	er the mode of dying	, such as car	rdiac or respiratory a	rrest,	Approximate Interval Between
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	anth certificate be executed BEM attending physicien end burial-transit to use as the burial-transit		resulting in death)	aDue to	(or as a conseq		- lung	Canc	<u> </u>		mon-tyls
			Constitution of the second	b							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to							
		Examiner	that initiated events	c							
Ö,	e exe ien e urial-	Ě	resulting in death) Last	Due to	(or as a conseq	uence of):					
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o	e de tha a	SICI	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregi 9☐Unkn	nant at time of d	eath 5	Other (specify)		-	MO	illi Day real
<u>.</u>	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	Ph.	Part II. Other significant conditi		la a Maria de la como	tain or in all			00. 04.		3
S,	signe I be o	þ	raitii. Other significant conditi	oris contributing to o	eath but not res	utang in trie ut	ideriying cause give	n in Part I.			ribute to the cause of death? 3 Probably 4 Dunknown
Ö	w requir been si should	sted							_ 'U	Yes 2□No	3 Probably 4 □Unknown
ec	law pash basis	Completed							24a. Was	osy 🧪 s	Were autopsy findings available prior to completion of cause of
<u>~</u>		Ş							perfo 1 ☐ Yes		death? 1 ☐ Yes 2 ☐ No
Vital Records,	cien sertifi Betor	Be	25. Was case referred to medica examiner?	-					Death (Check only o	ne)	
	Attending Physicien: The lav r deah. ector Alter this certificate has by the funeral director, page 2	2	1 ☐ Yes 2 Mo			ER/Outpatien		4 🔲 Nursii	ng Home 5 ☐ Resid		er (Specify) Hospice
č	ling F After uner	io i	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	19	of Injury oth, Day Year)	28b. Time of Injury	Work		28d. Describe I	now injury occurr	red
SEC	deah deah ctor , the f	cat	2 Accident investi 3 Suicide 6 Could	not be	111			′es 2□No			
Division of	l or Atter efter dea Director I in by the	Certification:	4 Homicide determ	ined 286. Place	e of Injury - At ho ing, etc. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (er or Rural Route Number,
	pital ours erei illed		20a Cartifier 1 7 Cartiful	o Dhualaine. To in				252000000			
	To the Hospital or Atternithin 24 hours effer deal To the Funerel Director completely filled in by the	edical	29a. Certifier 1 Certifyii (Check only 2 Medical one)	Examiner: On the D	asis of examina ner stated.	wiedge, deali	estigation, in my op	e, date and p inion, death o	lace, and due to the occurred at the time,	cause(s) and ma date and place, a	anner as stated. and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of pertifie				29c. License	number		29d. Date signed	d (Month, Day, Year)
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								147	10	HOLLI A	7-6- 1-8D 1
	^	1	30 Name and address of soccess	who completed on	sa of death (tre-	23a) /Tuna	Print)				2,2001
	7		30. Name and address of person	who completed cau	se of death (Item	23a) (Type,	Print)	u C+	R.IL	ins M	D 20201
	∩ Sta	te	30. Name and address of person E. Tso Mb 131. Date filed (Month, Day, Year)	lichey H	se of death (Item	838	N. Euta	w St	Baltin	rose M	23,2007 D 20201

Physician Month 17, 2007 1 1 17, 2007 1 1 17, 2007 1 1 1 1 1 1 1 1 1	_
John Raymond Jones Jones Jone	ate or Foreign
Funeral Director 4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital 5. Social Security Number 218-32-5724 Usuel Residence of Decedent 4b. City, Town, or Location of Death Havre de Grace Harford Havre de Grace 15. Social Security Number 218-32-5724 Usuel Residence of Decedent 4c. County of Death Harford Harford 4d. City, Town, or Location of Death Havre de Grace Funeral Director 7. Age (In yrs. last birthday) 70 Yrs. 70 Yrs. 4b. City, Town, or Location of Death Harford Harford 4c. County of Death Harford Harford 4c. County of Death Harford Harford Year) 9. Birthplace (Ste Country) Mary Land	e City Limits
Funeral Director S. Social Security Number 6. Sex 1 Director 2 Director 1 Director 2 Director 3 Director 4 Director 5 Director 5 Director 6 Director 6 Director 6 Director 6 Director 6 Director 6 Director 6 Director 7 Director 6 Director 7 Director 8 Director 9 Director 9 Director 9 Director 9 Director 9 Director 9 Director 9 Director 9 Director 9 Director 9 Director 9 Director 9 Director 9 Director 9	e City Limits
Director 218-32-5724 Usuel Residence of Decedent Age (mys. ast of Months Days Hours Min. (Month, Day, Year) Jun. 2, 1936 Mary Land	e City Limits
Usuel Residence of Decedent	
To a. State 10b. County 10c. City, Town or Location 10d. Insice	
Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	Tes 2x No
10e. Street and Number 3816 Willoughby Beach Rd. 21040 USA 11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Street and Number 3816 Willoughby Beach Rd. 12. Was Decedent Ever in U.S. Amed Forces? 1 Street and Number 3816 Willoughby Beach Rd. 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Street and Number 106. Zip Code 107. Zip Code 108. Citizen of What Country? USA 11. Marital Status 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American India Black, White, etc. 15. Yes 2 No Specify: White	
3816 Willoughby Beach Rd. 21040 USA 11. Marital Status 1	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyres 2 Mo Specify: White	
Specify: White	1,
15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry	
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16c. Crane Follower Steel Industry	
Crane Follower Steel Industry	
TO The Follower State of the Follower State	
James Taubman Jones Anna Elizabeth Carrigan	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	40
Eleanor K. Jones/Wife 3816 Willoughby Beach Rd., Edgewood, MD 210	
1 💆 Burial 2 🗆 Cremation 3 🗀 Removal from State	
4 Donation 5 Other (Specify) Gardens of Faith Cem 4-21-07 Baltimore, Mary 22. Name and Address of Facility	Land
21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A.	1000
23a. Part 1. Enter the disease, or complications that is used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approx	imate
shock, or heart failure. List only one cause of sach line.	Between and Death
Immediate Cause (Final disease or condition resulting in death) a. Due to (or as in nequence of): 2 the condition resulting in death)	TUNC
Examiner Aspiration Pneumonia	tert 5
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (br as a consequence of):	
V a g E Causa (Decade of Hydry) c. / Causa (Decade of Hydry) c.	arcs
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S C C C C C C C C C C C C C C C C C C C	Year
If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify) Month Day	Year
The state of the s	
The state of the past 12 months? 1 Yes 2 No 9 Unknown Part N. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23d. Date of delivery Month Day	
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	e of death? 4 □Unknown ings available
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in the past 12 months? A Pregnant at time of death S Other (specify)	e of death? 4 Unknown ings available of cause of Number,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25at 27 128 aven be Denoting 866 014/26/1076 Mental Hygiene 1 - For State Registrar 357 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month, Day 6: 30A M Corinne Odessa Keen 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner West Pratt Street Apt. 517 N/A Baltimore 6. Sex 8. Date of Birth (Month, Day, 03 b4 Birthplace (State or Foreign Country) **Funeral** Months 219.20.5386 1 □ M 2**X** F 90 Yrs. NO Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at MD Baltmore 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or West Draff Street Apt. 517 21201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? "natural", or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Ite ury or other traumatic event, the Medical Examine 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mercy Hospital Dietitian 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Singer J. Coldwell towell ora မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Verita Davis, Avenue Apt. G Balto MD 21206 Daughter 5010 Crenshaw 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of H Important: If Ite any Injury or ot once. 1 Burial 2 Cremation 3 Removal from State 04/21/07 Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Functal Services 21. Signature of Funeral Service Licenses 4905 York Road Baltmore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BLOOD acres /Medical Due to (or as a consequence of): Examiner BLEEDING if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine CERTIFICATION APPROVED BY MEDICAL EXAMI The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEFILLEACY 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury 27. Monner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Ailler 1X Natural 5 Pending n 24 hours a er death. e Funeral Lirector: All letely filled in by the fur 1 ☐ Yes 2 Accident investigation 3 Suicide ocation (Street and Number or Rural Route Number City or Town, State) Pla e of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. determined 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune (Check only one)

State Registrar

DHMH 17 Rev 1/2001

To the I

29b. Signature and title of certifier

A466 K/TA

31. Date filed (Month, Day, Year)

APR 2 6 2007

20065

2012

82. Registrar's Signature

12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOPMU

29c. License number

PE LEHSYLVA HIA

put

29d. Date signed (Month, Day, Year)

				Pleas	e Type or								egible.	
			For State Registrer		State	or maryla	and / Depa <i>Ce</i>		or Health a of Death	and Me		g. No.	2007	13574
			Decedent's Name ((First, Middle,	Last)						2. Date of Death)	V	3. Time of Death
E	Physicia /Medic		Sylvia Ke	arney						A	April	Day 7	2007	11:10 a M
þ	Examin	_	4a. Facility Name (If r	not institution,	give street and n	umber)		4b. City, Tov	vn, or Location o	of Death		4c. C	ounty of Death	
			1279 Isle			1		Pasa		24 Hrs	o Day of Dish		e Arund	
	Funeral Director		5. Social Security Nur		i.Sex 1		rs. last birthday) O Yrs.	Months D		Min.	8. Date of Birth (Month, Day, Sept 28,	Year)	9. Birth Cou	place (State or Foreign ntry)
å			214-22-85: Usual Residence of D								оерс 20 ₉	172		yland
	how			10b. County	1 . 1	10c.	City, Town or Lo							10d. Inside City Limits
	Ba-f a	Director		Anne Ar	undel		Pasade				140	la Chia	n of What Cou	1 ☐ Yes 2√ No
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23s or 28s-f show other than "natural", or items 23s or 28s-f show avent, the Medical Evandrar must be notified at		10e. Street and Numb					10f. Zip Co	21122			rg. Citize	USA	irito y r
	ne 23	Funeral	11. Marital Status		12. Was De	cedent Ever is	n U.S. 13.	Was Deceden	t of Hispanic Ori Cuban, Mexican		rfy Yes or No-	14	. Race - Amer	
Q	after or ther		1 🗌 Never Married	d 2 Marrie	Armed F d 1 ☐ Yes If Yes, G	2 X No		If Yes, specify 1 ☐ Yes 2X			lican, etc.)		Black, White	
8	ural', c	d by	3		Year or	Dates:							pecify: whi	
<u>.</u>	natu edica	Completed		 Decedent's y only highest 	Education grade completed)	16a. Dece	dent's Usual C kind of work of DO NOT use r	lccupation fone during mosi etired)	t of workin	g	16b. Kind	d of Business/la	ndustry
12	withir than	dwa	Elementary/Second	dary (0-12)	College	(1-4or 5+)			l practi			hea1	thcare	
Maryland 21215-0036		BeC	17. Father's Name (F	irst, Middle, La	ist)						(First, Middle, N			
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آو			1 🗆 Burial 2 🗀	Cremation 3	Removal foot	State	b. Place of Dispo cemetery, cre	matory or othe	r place)				,	,
altimore,	permit. Page Depertment of Important: If any injury or once.		4 Donation 5		. / /	46	2	2. Name and A	ddress of Facilit	ty				
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			23a. Part1. Enter the shock, or heart	disease, or o	omplications that	caused the d	leath. Do not en	ter the mode o	f dying, such as	cardiac or	respiratory arre	est,		Approximate Interval Between
	Physician		Immediat Cause (F	inal	Acc	ME (EREBI	W VAS	auga	He	+3OEA	7		Onset and Death Hours
i.	/Medical Examiner		resulting in death)	1	Due to	o (or as a con		- PAINCES			06/11/11/07 17/11			/ second second
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ď.	The law requires that the death certificate tie has been signed by the attending physogge 2 should be detached for use as the		Part II. Other signific	cant condition	s contributing to	death but not	resulting in the	underlying caus	se given in Part I	1.	23e. Did tob	acco us	e contribute to	the cause of death?
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E E	cate h		DIASE	TES /	ELLA	rus -	HTH	2205	cissos	575	• 1 ☐ Yes 2	2 No	death? 1 ☐ Yes	2 No
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ō	y Phys er this eral di	-	27. Manner of Death	200	28a. Dat	e of Injury onth, Day Yea	28b. Time	-	. Injury at Work?		8d. Describe ho			any)
ion	ath. r: Afte	atio	1	5 Pending investiga	ation	Jiniii, Day 16a	r) Injury	М	1 Yes 2	No				
Division of	To the Hospital or Attending Physician: The within 24 hours eiter death. To the Funeral Director: After this certificate his completaly filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	and 200. Fla	ce of tnjury - / Iding, etc. (Sp	At home, farm, s pecify)	treet, factory, o	office	2	28f. Location (St City or Town		Number or Ru	ral Route Number,
Ω	pital c	Ce	29a, Certifier	1 Cartifuing	Physicien: To t	ha host of my	knowledge des	th accurred at	the time, date ar	nd place a	and due to the co	ause(s) s	nd manner as	stated
	24 ho 24 ho Fun etaly	edical	(Check only one)	2 Medical E	xaminer: On the	basis of exar	nination and/or i	nvestigation, in	my opinion, dea	ath occurre	ed at the time, d	ate and p	place, and due	to the cause(s)
	To the Within To the	Me	29b. Signature and t	ille of certifier	7			29c. L	icense number		2	9d. Date	signed (Month	h, Day, Year)
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	(10)	-	30. Name and addre	ss of person v	no completed ca	use of death	(Item 23a) (Type	, Print)	Do-	- 6	Ω	10.	To Mas	2106/
			DAYFO KES 31. Date filed (Month	E M.D.	34572	Flogistrar's S	ignatuse)	PIMO	WIL	rs O	er bu	KN.	12/1	exclyb
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07-03018 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ralph E Keller State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Ralph Edmond Keller Month Day April 20, 2007 Medical Examiner 0524 hrs 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Southbound Interstate 495 @ Route 202 Prince George's Largo 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6 Sex **Funeral** oreign Alexandria; Months Days Hours Mir Director Country) 1 X M 2 Vac Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Glen Aller 1 Yes 2 No nrico hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country 10f. Zip Code 2305 $\Box a \cup$ Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes Yes, Give Yea Specify: (QUCASian Widowed Divorced Yes 2 X No specify 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 long of Health and Mental Hygiene. than, Baltimore, MD 21215-0036 Business Development Marketing Manager t: If item 27 is marked other other other other traumatic event, the Me 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Ral Keller W. Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) naly court Glen Allen Ann M. Keller 1708 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2 Cremation 3 Burial Removal from State 4-26-07 Kichmund . VA mportant: SVI Cremator Donation 5 Other Specify: 22. Name and Address of Facility 21 Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation services 6800 Harford Rol Parkville md 21234 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED 1 per me g866 4-27-07 vt physician a UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Fetal death Month Year past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate ✓ Yes 2 2 No 1 🗸 Yes To the Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) Be Hospital: Other₄ this Inpatient 2 ER/Outnatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 Yes ٩ After 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Apr 20, 2007 Driver auto truck collision 0454 hrs Natura Pending Yes 2 V No To the Funeral Director: completely filled in by the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Southbound Interstate 495 @ Route 202, Largo, MD determined (Specify) Interstate/Express Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Che Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 20, 2007 30. Name and address of person who completed cause of death (Item 23a Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State 2007 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month KOLDD2TSJ 2007 c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Manor Care **-**Rossville Rossville Baltimore Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1) Nov. 21, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number Days Hours 1 □ M Nov. 218-09-1733 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Perry Hall 1 ☐ Yes 2X☐ No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 101 Belhaven Terrace 21236 USA Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🖾 No Specify: 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Seamstress Union 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vincent Zagroba Unknown Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Gianotti- Niece 101 Belhaven Terrace Baltimore MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ty☐ Burial 2 ☐ Cremation 3 ☐Removal from State St. Stanislaus Cemetery 4/25/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles S Zeiler & Son 6224 Eastern Avenue Baltimore, MD 21224 23a. Part1. Ehrer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE Due to (or as a consequence of) Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☐ No 24a. Was an performed 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

MD

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Director

burial-trar the attending pl sate has been signed by the page 2 should be detached this

Physician/Medical Examiner ģ Be Completed funeral director, Medical Certification: To After

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the formula of

Division or Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner? 1 ☐ Yes

29b. Signature and title of certifier

27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide 4 Homicide

29a. Certifier

5 ☐ Pending investigation 6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year) 28b. Time of

5501

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) t CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year) 0

State Registrar

arena 31. Date filed (Month, Day, Year) APR 2 2007

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **Physician** 2007 Eleanor 9:45 Α. Lugenbeel April AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mariner Health of Glen Burnie Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 27 1 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☐ M 2 🐼 F 82 219-12-7137 Director MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be a 206 Welham Avenue N.W. 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1☐ Yes 2☐ No Specify: ò Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lile. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Coil Winder Westinghouse 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudolph Yankv Anna Kapas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Welham Avenue N. W., Glen Burnie, MD 21061 John A. Lugenbeel (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2007 Glen Haven Cemetery Glen Burnie, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure? List only one cause on each line. Immediate Cause (Final VASCULA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** REVIOL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2. ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy perform 1□ Yes 2[25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier empleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 4710 FEWNINGton KK has 101 D 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Medical

29a. Certifier

APR 2 7 2007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 Physician 12:55 PM 20, April William Russell Lamp Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Essex 702 Rockaway Beach Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 22, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months 1 M 2 ☐ F 85 Yrs. 219 07 1564 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County e filed within 72 hours after deeth with the Marylan al Hygiene.
other than "natural", or Iteme 23e or 28a-f ehow vent. I'm Medical Examinar mant be notified at 1 ☐ Yes 2X No Baltimore Essex Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 USA 702 Rockaway Beach Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, 11. Marital Status Black, White etc 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: WW II Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Contracting Electrician permit. Pages 1 and 2 should be filed w Depertment of Heelth and Mental Hygies Important: if item 27 is marked other it eny injury or other traumatic event. Its once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Margaret Grace Butler Anthony Joseph Lamp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 702 Rockaway Beach Avenue Baltimore, Maryland 21221 Evelyn G. Lamp (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 4/23/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) vice Licens 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Se 1407 Old Fastern Avenue Essex, Maryland 21221 Approximate Interval Between Onset and Death 25 Years Fart1 Enter the disease, or complication, or heart failure. List only on tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease of condition resulting in death) Years Hypertension Physician /Medical Due to (or as a consequence of): Examiner 1 Year General Debility Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): g physicien and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending | IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No deteched the 9 Unknown 9 Unknown ፩ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Depression 1 Yes 2 No 3 Probably 4 Unknown peen s old C.V.A. 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has 1 Yes 2 No certificate Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 this within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 X Naturaf 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Hospitel or To the Hospitel within 24 hours a To the Funerel C 💢 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D 17728 April 24, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ba Yin Oung, M.D. 8022 Bel Air Road, Nottingham, Maryland 21236 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 2 7 2007

			1 - State Amend #25,27&	State of Mar 28a-f G866				dental Hygi		13580
	Sk	136	Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
	°Physici		David Liversidge					April 2,	2007	10:50 PM™
) -	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Death		4c. County of Death	1
	LAGITIII	iei	Friends Nursing H			Sandy	Spring		Montgomer	·y
313	Funeral		5. Social Security Number 6. Sex	7. Age (I	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		nplace (State or Foreign untry)
	Director		159-18-7528 Usual Residence of Decedent	M 2□F	88 Yrs.	Months Days	Hours Min.	July 1,		sylvania
	death with the Maryland ms 23s or 28e-f show Frives he notified at		10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Man,	ţ	MD Montgome	ry	Sandy S	pring				1 ☐ Yes 2√☐ No
	1 the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	3E O		17310 Quaker Lane	C-25			20860		USA	
	ns 2	Funeral		2. Was Decedent Eve	er in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	ican Indian,
0	or Ite	E.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No				Rican, etc.)	Black, White	
m S	hours after turel', or Ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify:	white
5-0036	be filed within 72 hours after death with the Marylar ital Hygliene. Id other then "neturel", or items 23s or 28e-1 show event. The Marisal Ever-ther her relified at	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	dent's Usual Occup	pation	ing 1	6b. Kind of Business/l	ndustry un
7	within 72 ene. then "ne	ad.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of work d)	"'9		
2	gien gien er th	no.	12	5 `		chemist				
D	be filed ital Hygid of other event, to	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
<u> </u>	D 9 8 0	2	Thomas Lewis Li	versidge			Ava A	dams Yate	es	
Maryland	s 1 and 2 should if Health and Men item 27 is marke other treumatic.	ľ	19a. Informant's Name/Relationship (Ty						City or Town, State, Z	
	and 2 alth 27 I		Helen Liversidge/	spouse	1731	0 Quaker	Lane C-2	5 Sandy S	Spring, MD	20860
Baltimore,	Pages 1 and the Heat of Heat of Heat of Heat It item Iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ※Donation 5 ☐ Other Specify)	I	20b. Place of Dispo cemetery, crer	esition (Name of matory or other place		Date 2	Oc. Location - City or 7	Town, State
Balt	pernit. Pages Depirtment of Importent: If i any njury or once.		21. Signatur Fenneral Service License Ronald S. W.	ade, Direc		Name and Addre State Ana Saltimore		d 655 W.	Baltimore	Street
,	Physician		23 Part Enter the disease, show or heart failure. Ust only or Immediate C use (Final disease or con ion resulting in death)	cation that caused the e cause on each line.			ng, such as cardiac		st,	Approximate Interval Between Onset and Death
	/Medical Examiner		-	Due to (or as a c			9	, -	16,01J	Rus
	cuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c			11 11-	TY MEDICAL EXAMI	NER O	
3760,	ate be executed hysician and he burial-transit	ical	resulting in death) Last	Due to (or as a c	onsequence of):	OF RE	FICHTION APPROVED	, o		
.O. Box 68	The law requires that the death certificat tte has been signed by the attending phy age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
Records, P	w requires that the di been signed by the should be detached	by	Part II. Other significant conditions con	tributing to death but r	not resulting in the u	nderlying cause giv	ven in Part I.		acco use contribute to	the cause of death?
 တ္တ	w rec	Completed	0					24a. Was an	24b. Were au	topsy findings available
Ä	The law cate has page 2	E G						autopsy	ed2 prior to death?	ompletion of cause of
		o Co	GE Was associated to madical							2 No
Vital	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:		oth	on /	h (Check only one	*	
ō	Phys r this ral di	}	27. Manner of Death	1 Inpatient 28a. Date of Injury	2 ER/Outpatier	II 3 DOA	4 Vilursing Ho	me 5 ∐ Hesider 28d. Describe hov	nce 6 Other (Spec	iry)
0	ding h. Afte fune	tlor	1 ☑ Natural 5 ☐ Pending	(Month, Day Y	ear) Injury	Wor	rk? Yes 2 ∀X o			
<u></u>	Attendi death. ctor: A y the fu	ica	3 ☐ Suicide 6 ☐ Could not be	3-17-07	unkn		TAX	Subject	t Fell eet and Number or Ru	ral Route Number
Division	itel or Attending Phyris after death. rel Director: After thi lled in by the funeral of	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (е			City 1731(Sandy	O'Quaker L Spring MD	ane C-25
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	fedical	(Check only 2 Medical Examinate)	ician: To the best of n er: On the basis of ex and manner stated	amination and/or in	vestigation, in my o	pinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	With To	Z	29b. Signature and title of certifier	c Nei	ama	29c. Licens	46584	4 29	d. Date signed (Month	1, Day, Year)
			30. Name and address of person who co	Neil !	MD	Print)	nds	No	rsing	Home
	Sta Registr	-	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	all of		, , ,	J	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 12:12 AM 00 4 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Laion Memorial Age (Il yrs. last birthday) timo 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Davs Hours 1**Д**М 2□ F 231-18-6490 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show ner must be notified at 1 ☐ es 2 ☐ No Director ltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1218 Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 Pres 2 □ No If res; Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 1 ☐ Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life_DO NOT use retired) (Segondary (0-12) College (1-4or 5+) rans Dol permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglen Important: If Item 27 is marked other thi amy Injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surnanie, 's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not ente such as cardiac or respiratory arrest, Immediate Cause (Final Stenosis Oyeurs **Physician** fortic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause the Urderly cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-tran Due to (or as a consequence of) attending physician for use as the hiria Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. the 9 Unknown 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an autopsy performed?
1□ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate I or Vital 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this funeral 28d. Describe how injury occurred 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t Certification: Division To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q.M Union

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

32 Registrar's Signature

			For 1 _ Stata	State of Maryla	nd / Dep	artment		alth and N	Mental Hy	giene	007	13582
			Registrar 1. Decedent's Name (First, Middle, Las	A41		rincale	or De	aui	2. Date of De	Reg. No.	001	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Las						Month	Day	Year	
	/Media		Catherine	LeMa	у					4, 20		11:10 A M
ji.	Examir	ier	4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Loc	cation of Death	1		ounty of Death	
			Stella Maris				moniu				Baltim	
	Funeral		5. Social Security Number 6. S	□M 2DVE	. last birthday) Yrs.	Months		Under 24 Hrs. lours Min.	8. Date of Bird (Month, Da June 5,	h y, Year)	9. Birth	place (State or Foreign untry)
	Director	ļ	215-07-2489 Usual Residence of Decedent	94	113.				June 5,	1912	Mar	yland
	and		10a. State 10b. County	10c. C	ity, Town or Lo	ocation						10d. Inside City Limits
	f sho	5), 1 1 D 1.		D 1 1	1.1						1 ☐ Yes XXNo
	28a-	Director	Maryland Balti 10e. Street and Number	more	Parkvi.	10f. Zip	Code			10a. Citize	n of What Coi	intry?
	with a or	ā						27		U.S		,
	eath	Funeral	3005 Woodside Av	12. Was Decedent Ever in t	J.S. 13	Was Deced	212		pecify Yes or No		Race - Amer	ican Indian
	Iter of	Ë	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □ Yes 2 1 No		If Yes, spec	ify Cuban, N	Mexican, Puerto	pecify Yes or No Rican, etc.)	1	Black, White	, etc.
ဗ္ဗ	urs a	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No S	pecify:		S	pecify: Wh	ite
Ŏ	itled within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ehow ont, the Mydical Examiner must be mutiliad at	Completed	15. Decedent's Ed	lucation	16a. Dece	dent's Usua	Occupation	1	(16b. Kind	of Business/I	ndustry
2	hin 7 In "n Med	pie	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT us	k done durir e retired)	ng most of won	king			
7	gien th	PO	Unknown		Sa	les				Depar	tment	Store
g	be filed ital Hygi id other event,	Be	17. Father's Name (First, Middle, Last)				18.	Mother's Nam	ne (First, Middle,	Maiden Su	ımame)	
<u> </u>	Ments Ments rked	ည	Louis Conrad L	angkam				Anelia	a Gert	rude	Wiley	
Maryland 21215-0036	2 should and Men le marke aumatic		19a. Informant's Name/Relationship (7	Type, Print)	19b. Maili	ng Address	(Street and	Number or Ru	ral Route Numbe	er, City or T	own, State, Z	ip Code)
	1 and Heelth tam 27 other tr		Dennis Mather/Ne				oy Ct	. Time	nium M	D 21	093	
ore	of He		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □	Pamoval from State	Place of Dispo cemetery, cre.	osition (Nam matory or ot	ne of ther place)	İ	Date	20c. Loca	tion - City or T	Town, State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Important: If Item 27 le marked other than "natural; or Items 23a or 28a-f show expiritury or other traumatic event, the Mudical Examinat mant be notified at ance.		4 Donation 5 Other (Specify		rkwood	Cemet	ery	4/27/	2007	Balt	imore	MD
alt	permit. Depertrimporta		21. Signal use of Funeral Service Licen	S00	2	2. Name and	Address of	Facility	neral H	omo	Tnc	
<u> </u>	897		Ump	7/		6415	Bela	ir Road	Balti	more_	MD 21	206
			23a. Part1. Enter the disease, or construction shock, or heart failure. List only	olications that caused the dea	th: Do not en	ter the mode	of dying, su	uch as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition	Enlasto	ice (hro	1016	Obat	nictive	1/ /	ranguy	Onset and Death
	/Medical		resulting in death)	Due to (or as a conse	quence of):	-1/10	N//C	000	ractive	7)	MONIO
	Examiner		Sequentially list conditions	b						Dis	ease	
7	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse-	quence of):							
V	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
760,	te be executed ysicien and e burial-transit		losaning in dodiny East	Due to (or as a conse	quence of):						1	
		dicai	•	d		_						2
x 68	ertific ling p	Me	IF FEMALE:			1-1-						
Вох	ath contributions or us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	aldeath 3	Ectopic pre				236	 Date of delification Month 	very Day Year
0	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (spe	ecify)					,
<u>.</u>	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions o	ontributing to death but not re	culting in the u	and orbition of	usa awaa ia	Dort	220 Did to	abacco uco	contribute to	the cause of death?
Records,	signe signe			Similaring to addition for not to	soming in the d	indenying ce	idso givoii ii	i i ditti.		es 2.03		bably 4 Unknown
Ö	w require been sig should b	Completed										
ec Sec	elaw has b	idπ							24a. Was autop	an : sy med?	24b. Were aut prior to c death?	opsy findings available ompletion of cause of
_		S								2-12 No	1 Yes	2DE No
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			26 A Other:	. Place of Dea	th (Check only o	ne)		
	Phys this rat dir	ပ္	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 2			^	Nursing H	ome 5 Resid			ify)
ב	ding F th. After funera	lo	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	M	Bc. Injury at Work?	2 CINO	28d. Describe h	iow intuty o	ccurrea	
<u>s</u>	Attending Physician: r death. ector: Atter this certific by the funeral director.	Ical	2 Accident investigation 3 Suicide 6 Could not be	-1	lomo farm et			2 No	28f Location /	Stmot and I	Number or Bu	ral Route Number,
Division of	i ii ii ii	Certification:	4 ☐ Homicide determined	building, etc. (Speci	fy)	reet, lactory,	, onice		City or Tov	m, State)	Various of Trus	al riodio ridilibor,
_	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1 🔀 Cartifying Ph	ysician: To the best of my kn	owledge deat	h occurred s	at the time	late and place	and due to the	cause(e) or	nd manner an	stated
	e Ho. 24 h Fur etely	edicai	(Check only 2 Medical Examone)	ninar: On the basis of examin and manner stated.	ation and/or in	vestigation,	in my opinio	on, death occur	rred at the time,	date and pl	ace, and due	to the cause(s)
	ompl	Me	29b. Signature and title of certifier		11	29c.	License nu	mber		29d. Date s	signed (Month	. Day, Year)
	- > PT 0		1 Inghi	- No	Nt	1	>2	-741)	April	2	5M 2007
	6		30. Name and address of person who	completed cause of death (fre	m 23a) (Type	Print)				V		
	ソ		ERNESTINE WRIG				Y VALI	LEY ROA	D T	MONI	UM MD	21093
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign								
	Registr	ar	APR 2. 7	2007	12 1	hast.	9					

DHMH 17 Rev 1/2001

11:10 A.M.

APRIL 24, 2007

CATHERINE LEMAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryiana /	•	rtificate of		ına ivlei		ene g. No. 20	07	13583
1	Physicia	an	1. Decedent's Name (First, Middle, L	ast)						Date of Death Month	Day	Year	3. Time of Death
п	/Medic			arl Mead						pril 2			12:30A ^M
	Examin	er	4a. Facility Name (If not institution, g				4b. City, Town,		f Death		4c. County		. 1 . 1
, name i	202 - 500-01-1-1-1	4	2221 Indian Summ 5. Social Security Number 6.		e (In yrs. last	birthdav)	Oder		24 Hrs. 8.	Date of Birth		9. Birthol	
ш	Funeral Director		217-34-1652	1 X M 2□ F	69	Yrs.	Months Days	Hours	Min.	(Month, Day, lay 31,			ace (State or Foreign try) Jersey
	w	-	Usual Residence of Decedent 10a, State 10b, County		10c. City, To	own or Lo	cation					10	Od. Inside City Limits
	Maryli f sho led al	io	Maryland Anne A	runde1		0	denton						1X Yes 2 No
	with the Maryland a or 28a-f show be notifled at	Director	10e. Street and Number	runder			10f. Zip Code			10	g. Citizen of V	Vhat Coun	try?
	th with		2221 Indian Summ	er Drive			2	1113			United	l Sta	tes
	r dea ems er mu	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of If Yes, specify Cu	Hispanic Original	gin? (Specifi , Puerto Ric	y Yes or No- an, etc.)		e - America	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tial Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1√ Yes 2 ☐ N If Yes, Give Year or Dates:1	955−75		1□Yes 2X No				Specify		ite
- 2	72 ho natur lical B	Completed	15. Decedent's (Specify only highest of	Education	1.1	(Give	dent's Usual Occu	durina most	t of workina	1	6b. Kind of Bu	siness/Ind	lustry
2	/ithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use retir	ed)					
2	iled w Hygie Iher tl		17. Father's Name (First, Middle, La.	5+		Elec	trical E		-	First, Middle, M	NASA		
auc	≥ = = o	o Be	Wilfred J. Me	_						Ashaue		,	
<u> </u>	12 should be filed v h and Mental Hygie 7 Is marked other t traumatic event, th	ĭ	19a. Informant's Name/Relationship		1	9b. Mailir	ng Address (Stree					State, Zip	Code)
Š	5 # 2 1		Gwen A. Schlemme	r/wife	2	2221	Indian S	ummer	Drive	0dent	ton, Ma	rv1a	nd 21113
e,	es 1 al of Hea fitem r othe		20a. Method of Disposition				sition (Name of matory or other pl		Date		Oc. Location -		
Ĕ	Pages ment of ant: If its ury or o		1 ☐ Burial 2X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	ify)	1	Arun	del Crem	natory			Odenton	-	•
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Sign fare of Funeral Service Lis			D 1 /	2. Name and Addi onaldsor 11 Annap	ress of Facility Funer	al Ho	me & Ci	remator	y, P	·A.
			23a. Parti. Enter the disease, or co shock or heart failure. List on	mplications that caused	the death, D							Tanu	Approximate Interval Between
Ē	Physician	0	Immediate Cause (Final	ly one cause on each lin			CAN					- 1	Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as			C/01-0	217001	7173)				77432
	Examiner		Sequentially list conditions,	b									
	7 ti	iner	cause. Enter Underlying Cause (Disease or injury	Dua to lor as	a consequen	ce of							
X	ecute and I-trans	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequen	ce of):							
68760,	ificate be executed g physician and as the burial-transit			d	,								
	= D m	ledical									1		
Box	leath certifi attending I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	pf pregnancy 2 ☐ Fetal de	ath 3[∃Ectopic pregnan	cv				e of delive	
	The law requires that the death cert tte has been signed by the attendingage 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown			Other (specify)	•			Mo	nın	Day Year
<u>М</u>	ires that the de signed by the a be detached		Part II. Other significant conditions	contributing to death b	ut not resultin	a in the u	nderlying cause o	iven in Part I		23e. Did toba	acco use contr	ribute to th	e cause of death?
Vital Records,	signe d be c	l by	Takin onet olgimount oonanen	o and a second s		giirtiio a	naonying sauce g	.voii iii i die i.		1 ☐ Ye			ably 4 □Unknown
Sor	w require been signature	etec								24a. Was an	24h 1	Nere auto	psy findings available
Ř	The lav	Completed								autopsy perform	led?	prior to cor death?	npletion of cause of
ā			25. Was case referred to medical					26. Place	of Death (C	1 Yes 2 Check only one		I∐Yes	2 0 000
	ysici is cer direct	o Be	examiner? 1 □ Yes 2 ☑ 1 0	Hospital: 1 ☐ Inpatie	ent 2□ER/	Outpatier	nt 3 DOA O	hor		52 Resider		er (Specify	<i>ı</i>)
0	ding Ph h. After thi funeral	T:u	27, Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day		b. Time o	f 28c. Inj			l. Describe hov			
Sio	endii eath. or: A	satic	2 Accident investigati	on			M 1[∐Yes 2∐l	No				5US
Division or	I or Attend after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home c. <i>(Specify)</i>	, farm, str	eet, factory, office	•	28f.	Location (Str. City or Town,	eet and Numb State)	er or Rura	I Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical C		Physician: To the best of aminer: On the basis of and manner sta	f examination								
	To the within To the compl	Me	29b. Signature and title of certifier	(100)	/		29c. Licer	nse number	c/	1	d. Date signed		
•			1 75	Matin	1de-			811					2007
	15+1		30. Name and address of person who SP WATIKI	NS SVI	012 36		Print) 900 (F)	FIJT 6	BrE.	ND 80	mome	213	m 2140
	Sta		31. Date filed (Month, Day, Year)		ar's Signature	1	e,						
	Registr	ar	APR 2 7 2007	1 September 1	St. A								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23a, State of Maryland / Department of Health and Mental Hygiene

1- For Amend Items 25,27,28a-1 per me 2806,04/26/07dhb

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Doroth **Physician** 7500 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Northwest Hospital Randallstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 T F 577-03-4761 91 **Director** 21, 1915 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mential Hygiene. Important: or items 23a or 28a-f show Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X☐ No Director Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 945 Elmridge Avenue 21229 Completed by Funeral United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ∑XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Edward Fulton Edna Beall ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda A. Nitsch - Daughter 3222 North Rolling Road, Baltimore, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Meadowridge Memorial 4-16-2007 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Elkridge, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Road, Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last SYMEDICAL EXAMINER Physician/Medical Examine The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) CATIO Division or Vital Records, P.O. Box 68760, CERTIF After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day 5 Other (specify) I□Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2[1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA Inpatient 28b. Time of Date of Injury (Month, Day Year) 27. Marrier of Ceath 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Subject fell. 03/26/2007 Unknown M 1 ☐ Yes 2 X No X Accident investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 945 Elmridge Ave., Balto., MD Home To the Hospital 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Robert J. Morrison, Jr.	State of Maryland / Department of Healt

		1- For State Registrar			Certifica	ate of	f Death			R	eg. No	Erm 49			ř
Physicia		1. Decedent's Name (First, Midd	lie,Last)						2	2. Date of Dea Month		Year		3. Time of Death	
ledical Exami	ner	Robert Ja			, Jr					April 23, 2	2007	Tear		1833 hrs	
		4a. Facility Name (if not institution 3573 Brickwall Lane	on, give street and n	umber)			4b. City, Town, or i	Location o	of Death			c. County of Anne Arui		•	
ign		5. Social Security Number	6. Sex	7 450	(In yrs. last birt	-day)		1 16 1 1- 4-	a 0.411m	O Data of D					_
Funeral Director		,		7. Age		nuay)	If Under 1 Year Months Days	_		is. Date of bi	пп(ММ		Foreign	hplace (State or	
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any		Usual Residence of Decedent 10a. State 10b. County		11	0c. City, Town	or Locat	ion							10d. Inside City Limits	_
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ith the 23a c		3573 Brickwall 11. Marital Status				40.144	21122					USA			_
ath w items	Funeral	1 X Never Married 2 N	12. Was De larned Armed F	orces?_			is Decedent of Hisp es, specify Cuban,)-	14. Race - / White,		can Indian, Black,	
21215-0036 Mental Hygiene. Maryland Hygiene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once			1 Yes vorced If Yes, Give Ye		No	1	Yes 2 X No	snerify:				Specify: W	Th i i		
urs af tural'	d by	15. Decedent's Education (Spe	or Dates:		leted) 16a. [nt's Usual Occupati		kind of wo	rk done	16b.	Kind of Busin			_
15-0036 filed within 72 hours after. Hygiene. d other than "natural", o , the Medical Examiner o	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of working life.	DO NOT	use retire	d)				,	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	ldu	12th	ø			nsu	lator					Factor	.A.		
5.0 led w tygie other	CO	17. Father's Name (First, Middle	, Last)					8.Mother	s Name (First, Middle,			<u> </u>		_
21215-(uld be filed v Mental Hygi marked oth	Be	Robert James M		Sr.				Jane							
	욘	19a. Informant's Name/Relations	ship (Type, Print)		195	. Mailing	Address (Street	and Num	ber or Ru	ral Route Nur	nber, C	City or Town,	State,	Zip Code)	
MD 1d 2 shot alth and 1m 27 is a sumatic		Robert J. Morr	ison, Sr.	/Fat			Brickwall								
ore, ME es l and 2 s' of Health ar If item 27 her traums	- 1	20a. Method of Disposition 1 X Burial 2 Crematio	n 3 Removal f	rom State			sition (Name of cem her place)	netery,		Date	20c.	Location - C	ity or	Town, State	
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If iten 27 is marked injury or other traumatic event,		4 Donation 5 Other S	pecify:		Union		metery							le, MD	
Salt ermit. epartr nport	. //	21. Signature of Funeral Service	Licensee			22. 1	lame and Address	of Facility	Dona	aldson	Fu	neral	Hon	ne, P.A.	1
_ =====		CRS			00770	32	l3 Talbot	t Av	enue	, Laur	el,	MD 2	070	7	
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	r complications that one on each line.	caused th	e death. Do no	t enter ti	he mode of dying,	such as ca	ardiac or r	espiratory arr	est, sh	ock, or heart		Approximate Interval Between Onset and	
Examiner	9	Immediate Cause (Final disease	-			Head								Death	ľ
		or condition resulting in death)	Due to (or as a	a conseq	uence of):										
	-	Sequentially list conditions, if any, leading to immediate	Due to (or as	e consequ	uence of):								_	<u> </u>	_
`	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	С												
isi od / / /	Ха	events resulting in death) Last	Due to (or as	a consequ	uerice of):										_
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20 00 50	Ž	IF FEMALE: 23b. Was decedent pregnant in t	he 23c. If yes,		of pregnancy	Fe	tal death 3	Ectonic	pregnanc	~	23	3d. Date of de Month		ay Year	
x 61 h cert tendir	cia	past 12 months?	4 Pregr	nant at tir			her (Specify)	Lotopic	pregnant	-y	1	MORE	D.	ay Year	
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 Un	known g death Unkn						-		1				
P.O. Box 68 se that the death certi gned by the attendin		Part II. Other significant condi-	tions contributing t	o death b	out not resulting	in the u	ınderlying cause gi	ven in Par	rt I.					he cause of death?	
, P.C ires that signed to d be deta	Completed by		_				_			1 Yes	2	/ No 3	Proba	ably 4 Unknown	
ords, w requires been a should	ete									24a. Was autop				opsy findings available impletion of cause of	,
Recol The law icate has	Ĕ					-	-			perfo	rmed?	dea	eth?	·	
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Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been sted in by the funeral director, page 2 should	o Be	examiner?	Hospital:	Inpatient	2 ER/0u	ıtpatient		Other ₄		Home 5	Reside	ence 6 🗸	Other:	Scene	-
n of ling Ph After t funeral	-1	27. Manner of Death	28a. Date	of Injury	28b. T	Time of In	njury 28c. Injury	y at Work?		8d. Describe					-
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Visi or At fler d jirect in by	ا≝						et, factory, office bu	uilding, etc		8f. Location (Street a	and Number	or Rur	al Route Number, City	
pital Durs a Billed Filled	Cert	4 Homicide dete		Singl	e Family				35	or Town, S 573 Brickwa	itate) II Lane	e, Pasaden	a, MC)	ļ
Division of Vital Records, P.O. Box 6 not the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendition to the Funeral Director, and the funeral director, page 2 should be detached for use.		29a. Certifier (Check only 1 Certifying P	hysician; To the be	st of my k	nowledge, dea	th occur	red at the time, dat	te and plac	ce, and do	ue to the caus	e(s) ar	nd manner as	state	d.	
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director:	Medical	\ .	miner:On the basis and manner s	of examir stated.	nation and/or in	vestigat	io⊓, in my opinion,	death occ	urred at t	he time, date	and pla	ace, and due	to the	cause(s)	
	Σ	29b. Signature and title of certific	er A				29c. License	number			29d.	Date signed	(Mon	th, Day, Year)	
,		(/) andert	eus)				O.C.N	1.E.			Apr	il 24, 200	7		
P		30 Name and address of person			. ,										-
`			ssistant Medica			Penn	Street, Baltim	ore, MI	2120	1					
St Regist	ate	31. Date filed (Month, Day, Year)		egistrar's	Signature	1									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** 58 AM F005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 311 Waveland Road Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday **Funeral** Days 1 M 2 □ F Director 053-30-2366 70 Jan. 25, 1937 New York Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at Maryland Baltimore Catonsville 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 311 Waveland Road 21228 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or items 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status other traumatic event, the Medical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 □ No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housing Realtor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael J. Molloy Beatrice Coleman ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is any Injury or other trau once. Carol S. Molloy 311 Waveland Road; Catonsville, Maryland 21228 Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 4/27/2007 4 Donation 5 Other (Specify) Catonsville, Maryland 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Furieral Service Licensee. 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or implications that combined shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Julmonale disease or condition resulting in death) 01 /Medical consequence of) Due to (or \$ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (a Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed RR Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death Day 5 ☐ Other (specify) by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death3 Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Monknown demo 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ate has page 2 s autopsy performed certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 | Yes 2 DK 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. contine 29c. License number leted cause of death (Item 23a) (Type, Print) nces

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

				For State Registrar	State of Maryl		artment of Fertificate of	Death	F	Reg. No.	13587
	×	Physici	an	1. Decedent's Name (First, Middle, La MINNA B. McALLIST					2. Date of Dea Month	Day Year	3. Time of Death
		/Medio		4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location of Death	APRIL	25 2007 4c. County of Deat	11:05P M
				7006 New Cut Rd.			Kings			Baltimo	
,	1/26	Funeral Director		Z10*1Z*0033	6ex 7. Age (In) □ M 1	yrs. last birthdaj Yrs.	Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birti (Month, Da) June	%, Year) 9. Birt 30,1917 Vi	hplace (State or Foreign untry) rginia
2		yland sow		Usuaf Residence of Decedent 10a. State 10b. County	100.	. City, Town or	Location				10d. Inside City Limits
M		ith the Marylar or 28a-f show	ctor	Maryland Baltimo	re	Ki	ngsville	- Baltimor			1 □ Yes 2 🗓 🂢 o
1		death with the Maryland rms 23e or 28e-f show rmast be radified at	Director	10e. Street and Number			10f. Zip Code	7		10g. Citizen of What Co	untry?
7		me 23e	Funeral	7006 New Cut Rd.	12. Was Decedent Ever	in U.S. 13	2108 Was Decedent of I	Hispanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
771	5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Item 27 is marked other then "natural", or itama 23a or 28a-1 ahov other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married ※ ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	san, Mexican, Puerto F	Rican, etc.)	Black, Whit	hite
2		"natu	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Giv	edent's Usual Occup re kind of work done DO NOT use retire	during most of working	ng	16b. Kind of Business/	Industry
8	2121	2 should be filed within and Mental Hygiene. is marked other then " aumatic event, the Mar	ошо	Elementary/Secondary (0-12) 9 yrs.	College (1-4or 5+)		sewife	ia)		Housekeepi	ng-Own Home
		be filed tal Hygi d other event,	BeC	17. Father's Name (First, Middle, Last				18. Mother's Name	(First, Middle,		
7	Maryland	should bent marked umarke	To	James Elliott				Mary Wy			7. 0. (.)
INNA	Mar	d 2 sh th and th is m traum		19a. Informant's Name/Relationship (Patricia Sieracki						or, City or Town, State, 2 Md. 21087	zip Code)
2	ē,	s 1 and 2 of Health itsm 27 i		20a. Method of Disposition	20	b. Place of Dis	position (Name of rematory or other pla	. D	ate	20c. Location - City or	Town, State
1	altimore,			1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			rematory	4-27-	2007	Baltimore,	Md.
Z	Balt	permit. Pag Depertment Important: I any injury o		21. Jig at re of Funeral Service Libe	nsee Schn	- 1	22. Name and Addre 11750 Bel			sahn Funera le, Md. 210	
				23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the cone cause on each line.					rest,	Approximate Interval Between Onset and Death
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	AGE.	BRONCI	hial Ca	ncer		41
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		be executed sicial and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Hyper 7	rsequence of);	m WI	The taxo	110 m	egely	905
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	D. Box	Physician: The law requires that the death certificate hes been signed by the attending Ir this certificate hes been signed by the attending Ir all director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pro 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death	B Ectopic pregnand Dipole (specify)	Ey		23d. Date of de Month	livery Day Year
	P.O.	es that the de igned by the be detached	/ Ph	Part II. Other significant conditions	contributing to death but not	t resulting in the	underlying cause g	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
	of Vital Records,	quires n sign utd be	ed by						101	Yes 2□No 3□P	robably 4 🗷 Unknown
	000	e law requir hes been s je 2 should	Completed						24a. Was autop		utopsy findings available completion of cause of
	Ä	The I	Com						perfo 1 ☐ Yes	rmed? death?	an.
	Vita	sician: Th certificate rector, pag	o Be	25. Was case referred to medical examiner? 1 1 Yes 250 No	Hospital:	0∏ FB/0	all no. Ot	26. Place of Death			
	on of	Jing After		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpat 28b. Time ar) Injun	of 28c. Inju	4 Nuising noi		dence 6 □Other (Spe how injury occurred	кшу
	Division	• Hospital or Attendi 24 hours after death. • Funeral Director: A etely filled in by the fu	Certification:	3 Suicide 6 Could not to determined	28e. Pface of Injury - building, etc. (Sp	At home, farm, pecify)	street, factory, office	, 4	28f. Location (: City or To	Street and Number or R wn, State)	ural Route Number,
		To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medicai C		hysician: To the best of my miner: On the basis of exa and manner stated.						
		To the within 2 To the complet	Σ	29b. Signature and tytle of certifier	eilly,	MD	29c. Licen	4749		April 2	th, Day, Year) LOGI Md 21228
-		h		30. Name and address a person who	completed cause of death	(Item 23a) Typ	e, Print)	ce Dans	B	Hurse	11/2/728
	7	St	ate	31. Date filed (Month, Day, Year)	32. Pagistrar's S	Signature	ing cro	S KURU,	Mul	10000	االد در در
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10:58 AM **Physician** 23 Elly Maszun APRIL 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SAMAR(TAN) BACTIMORO HOSPITAR N/A| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 25,1925 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1 □ M 2 🔼 F Germany 212-34-5440 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 X Yes 2 □ No Baltimore N/A Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number be o United States 21212 908 Reverdy Road permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must be Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1XX Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 White Specify. Specify: <u>م</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A City of Baltimore Payroll Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Becker Gustav Maszun 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1406 Joppa Forest Drive Apt.R Joppa, MD. 21085 Mr. Alfred W. Maszun (Brother) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 28 1 Burial 2 □ Cremation 3 ☐Removal from State Dulaney Valley Mem.Gard. 2007 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22 Name and Address of Facility}
Peaceful Alternatives Funeral&Cremation Ctr.,P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service License Jeffrey L. Gair Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or complicative ist only one 23a. Party. First the dise at shock, in his at failure. Immediate Cause (Final disease or condition resulting in death) HYPORIC HYPERCARBIG **Physician** /Medical Due to (or as a consequence of): **Examiner** OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): bunial-transit Due to (or as a consequence of) Box 68760. physician Physician/Medical the as signed by the attending I IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 ☐Unknown 1 ☐ Yes HEART Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No PAILURD 24a. Was an autopsy performed? 1∏ Yes 2 400 Division or Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director. Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 27. Manner of Death 28c. Injury at Work? or Attending 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C Hospital Levertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. PHYSICIAN 29c. License number POO 6.32.35 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of



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son who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deatl 1. Decedent's Name (First, Middle, Last) Month Day Physician 2007 7:24 A.M Georgie E. Matthews 23 April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harwood Anne Arundel County Mandrin Hospice House Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1□M 2XF Maryland 213-14-5778 Jan.11,1920 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Anne Arundel Co. Harwood Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20776 United States 3675 Solomons Island Road Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. ant; If Item 27 Is marked other than "natural", or Items 23. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Hommaker 12 N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary A. Werner Gordon King ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health ar t: If item 27 is y or other trai 730 Jupiter Hills Court, Arnold, Maryland 21012 Mrs. Suzanne L. Gingher (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or Evans Funeral Chapel Apr. 25, 2007 Forest Hill, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Leaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MMT Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician ar s the burial-t Division or Vital Records, P.O. Box 68760, Physician/Medical as t attending for use as IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 No 9 ☐ Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by No. 3 ☐ Probably 4 ☐ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page 2 perforn 2 No this certificate 25. Was case referred to medical 26. Place of Death Check onl one Certification: To Be examiner' Hospital Other: 20 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6/XOther (Specify) 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After completely filled in by the funeral 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signatule of certi

State

Registrar

31. Date filed (Month, Day, Year)

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2007

30. Name and address of person

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 2944 20°**0**≈7 1:05p **Physician** MArtin Harry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Baltimore Heritage Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 11, 1912 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Ohio 94 376-01-6561 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show 1 Yes 2 No the Medical Examiner must be notified Director Baltimore Essex MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò USA 21221 1012 Foxridge Lane or Items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturar", or Iten any injury or other traumatic event, the Medical Examina Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No þ 3 → Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
TOOL & Die MAker 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Unit Tool 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Meyers William Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1012 Foxridge Lane Baltimore MD 21221 /daughter Barbara Adams 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation /5 ☐ Other (Specify) Bayview Crematory 4/26/07 Baltimore MD /5 ☐ Other (Specify) 21. Signature Juneral Service Liver see 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trar Records, P.O. Box 68760, Physician/Medical use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ulliknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform certificate I 2 Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Dursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ¥6 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 Tes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month Day, Year) 32. Registrar's Signature Year) State Registrar

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cause of death (Item 23a) (Type, Print

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	death ms 23	era	11. Marital Status		12. Was Dec	cedent E	ver in U.	S. 13.			lispanic Origin? (S an, Mexican, Puen	pecify	Yes or No		14. Race - Ar		ian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then *neture!', or items 23e or 28e-f ehow with injury or other traumatic event, the Medical Exeminar maint be notified at ance.		1 ☐ Never Married 2☐ 3X Widowed 4 ☐ Divo		Amed F 1 Yes If Yes, G Year or	2 □ No	>			2̷ No	Specify:	IO HIC	an, etc.)		Black, WI Specify:Wh		
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J	Physician /Medical Examiner portal-transit	ai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	Due to	o (or as a	consequ	uence of):			ART F						
P.O. Box 68760,	that the death certificate be ed by the attending physicit detached for use as the bu	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23c. If yes, o	birth 2 gnant at t	2 ☐ Fetal	Ideath 3	Ectopic Other (pregnanc specify)	1				23d. Date of o	lelivery Day	Year
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical Ce	29a. Certifier 1 🖫 Cert (Check only 2 🗌 Med	fying Phy cal Exemi	ner: On the	ne best of basis of inner state	examina	wledge, deat tion and/or in	h occurre vestigation	ed at the ti	me, date and place pinion, death occu	e, and	I due to the at the time	cause , date a	(s) and manner nd place, and d	as stated. ue to the c	ause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 2007 **Physician** 5:45 A. M Jerome F. Noyes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford County 2202 Hampshire Drive Fallston Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

March 25,1929

9. Birthplace (Sta Country)

Maryland Social Security Number 7. Age (In yrs. last birthday, Days Months 1X M 2□ F 78 220-20-2129 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Harford County Fallston Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21047 2202 Hampshire Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) St. Regis Paper Co. Machinist N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine R. Seidl Jerome Francis Noyes, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2202 Hampshire Drive, Fallston, Maryland 21047 Mrs. Betty Noyes (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 □Removal from State 4/28/0 Forest Hill, Maryland Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) encenna 61/2 years Due to (or as a consequence Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Probably 4 Unknown 1 ☐ Yes

Physician /Medical **Examiner**

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after death

and Mental Hygiene. Is marked other than

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other th any Injury or other traumatic event, the once.

Baltimore, Maryland 21215-0036

bunial-trar physician a the burial attending ph signed by the a this funeral After t after death Director:

Hospital or Attending Physlclan: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical 2 Completed Be Certification: To Medical

25. Was case referred to medical examiner? 27. Manner of Death 1 Natural

29a. Certifier

29b. Signatur

2 Accident

3 Suicide

4 Homicide

1 🗌 Yes

2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital:

28a. Date of Injury

(Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

29c. License number D 45390

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year) April 25, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy performed 1 Yes 2 ₩

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

My Min (N.D.) GOZ South Atward Road # 200, Bel Air 31. Date filed (Month, Day, Year)

State Registrar

APR 2

5 ☐ Pending investigation

6 ☐ Could not be

determined



within 24 hours a

the

2

Amend Item State of Maryland / Department of Health and Mental Hygiene 23a25, per me, 8866,04/26/0/dhb.
Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Joseph Alan Plummer Apri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital of Baltimore Baltimore city Joseph Plummer | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec • 21, 1958 6. Sex 1 AM 2 ☐ F 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 214-66-7370 48 Director Usual Residence of Decedent 10c. City. Town or Location 10a State 10h County Director Maryland | Baltimore County Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 7 21008 York Road United States of America 21120 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status KNOWN as 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Joseph Plummer Betty Louise Schuman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21008 York Road Parkton, Maryland 21120 Mrs. Betty Burggraf (Mother) Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State to Important: If its any Injury or o once. April 18, 2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License eaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Jord Hallan Due to lor as a consequence of): **Physician** /Medical CENTERCATION APPROVED BY MEDICAL EXAMINE Examiner Serviero Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner and I-transit Due to (or as a consequence of): 68760 attending physician for use as the buria Physician/Medical Box IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Ö 9☐Unknown 9 Unknown signed by t d be detach ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown traumanc brain Mury Syndrome 24a. Was an has autopsy performed? Yes 2 ☑ No page certificate Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 12 No 9 ō 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Owithin 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 -3) MD

Registrar DHMH 17 Rev 1/2001

State

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APR 2 6 2007

Tritha 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Chosh

2401 W. Belvedere Avenue, Sinai Hospital of Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign
Country)

10d. Inside City Limits 1 ☐ Yes 2 No

08:13AM

Day

2007

N/A

Maryland

14 Bace - American Indian

Disabled

Forest Hill, Maryland

well

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No

Year

Month

April 13,2007

Approximate Interval Between Onset and Death

10 days

Black, White, etc.

specify: White

4c. County of Death

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For	State	of Maryla	nd / De	partment of	Health a	and N	/lental H	ygie	ene		
			State Registrar			C	ertificate of	Death			Reg	. No. 2	107	13596
П			1. Decedent's Name (First, Middle,	Last)						2. Date of I	Death	Day	Year	3. Time of Death
	Physicia /Medic		Bernadette H.	Puls						April	23	, 200		6:10 a ^M
È.	Examin		4a. Facility Name (If not institution, g	give street and n	ımber)		4b. City, Town,	or Location	of Death			4c. Count	ty of Death	
	and the second s	Sal	709 Maiden Choic				Catons		04 Hea	0 0-4-45):aL	Balt:	imore	(2)-1
	Funeral			. Sex 1	7. Age (In yrs	s. <i>last birthda</i> Yrs	Months Dave		Min.	8. Date of E (Month, I	Day, Y		Cour	
и	Director		217-18-5189 Usual Residence of Decedent		86				L	Jan. (ο, 1	921	Mary	Idiia
	tand ow it		10a. State 10b. County		10c. C	ity, Town or	Location						1	0d. Inside City Limits
	Mary Fied a	tor	Maryland Baltim	ore	Cat	onsvi	11e							1 □Yes 2√ No
	h the	Directo	10e. Street and Number	710	, 00.	2011012	10f. Zip Code				100	j. Citizen of	What Cour	ntry?
	th wit		709 Maiden Choic	ce Lane	CC207		21228				U	SA		
	ems er m	Funeral	11. Marital Status	Armed F		U.S. 1	Was Decedent of If Yes, specify Cu	Hispanic Or ban, Mexica	rigin? (Sp ın, Puerto	pecify Yes or I o Rican, etc.)	No-		ace - Americ ack, White,	
20	s afte	by Fi	1 Never Married 2 Married	If Yes, G	art No live		1 ☐ Yes 2 💽 No	Specify.	:			Spec	ify: Wh	ite
ğ	filed within 72 hours after death with the Maryland Hybione. ther than "natural" or Items 23a or 28a-f show the the Medical Examiner must be notified at	d bé	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or	Dates:	16a De	cedent's Usual Occ	upation	-		16	b. Kind of I	Business/In	
<u>ဂ</u>	n 72 i "na ledic	olete	(Specify only highest	grade completed		(G life	ive kind of work don e. DO NOT use retir	e during mos ed)	st of wor	king	1			•
25	with iene. thar	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	Admi	nistrativ	e Ass	st.		K	ey Pr	ess	
ğ	be filed within 72 hours after death with the Marylar to Hydione. An other than "natural", or Items 23a or 28a-f show they the Medical Examiner must be notified at event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, La	ast)				18. Moth	er's Nam	ne (First, Midd	ile, Ma	aiden Surna	ame)	
<u>a</u>		To E	John G. Kines					Heler	n L	ingerm	an			
ar Z	0 0 0	ľ	19a. Informant's Name/Relationship	(Type. Print)		ł	ailing Address (Stree					-		Code)
≥ .	12 # Z		C. Douglas Puls-	son	DOL		Encore Ct		ntre	<u>ville,</u> Date			7 n - City or To	State
Ö	0 0 - -		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	B □Removal from	n State	cemetery,	sposition (Name of crematory or other p				}		-	
<u>=</u>	t. Pa tmen tant: ijury		4 □ Donation 5 □ Other (Spe		Me	etro C	rematory			/2007	C	atons	ville	, MD
Baltimore, Maryland 21215-003	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Li	censee		- 1	Gary L. K	aufmar	n Fu	neral_!	Hom	e at 1	MMP,	INC.
			23a. Part1. Enter the disease, or c	omplications that	caused the de		7250 Wash						MD_2.	Approximate
			shock, or heart failure. List o	nly one cause on	each line.	1	.\0	, ,,						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	o (or as a conse	equence of):	1.01							
	Examiner				`	•								
	Contract of the last	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D. Due t	o (or as a conse	equence of):							- 17	
$\sqrt{}$	ecutec nd rransi	Examiner	that initiated events	С										
Ö,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	Due t	o (or as a conse	equence of):								
8760,	cate b	dical	`	d	-									
9 ×	certific ding p	/Me	IF FEMALE:	23c If yes, o	outcome pf preg	inancy						234 [Date of deliv	an.
Box	leath certific attending p for use as f	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 □ Live	e birth 2 ☐ Fe	etal death	3 ☐ Ectopic pregnar						Month	Day Year
P. O.	w requires that the di been signed by the should be detached	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unl			,, ,,							
	that ned b		Part II. Other significant condition	s contributing to	death but not re	esulting in th	e underlying cause	given in Part	I.	23e. D	id toba	acco use co	ontribute to t	the cause of death?
<u>rd</u> s	quires n sign	d by								1	☐ Yes	22 No	3 ☐ Pro	bably 4 ☐Unknown
ပ္ပ	law reas bee	Completed								24a. W	as an		b. Were auto	opsy findings available ompletion of cause of
ž	The lay	mo.								pe 1□ Ye	erform	ed? ☑No	death? 1 ☐ Yes	•
ta	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						ce of Dea	ath (Check on	ly one)		
Ž	Physic this ce al dire	To E	1 Yes 2 No			☐ ER/Outpa	TIGHT 3 DOX		lursing F	lome 5 A				fy)
u C	ding P. After t		27. Manner of Death 1 Natural 5 Pending	(M	te of Injury onth, Day Year)	28b. Tim Inju	ıry V		7No	28d. Descril	be hov	v injury occ	urred	
<u>sio</u>	tend leath. tor: /	cati	2 Accident investiga 3 Suicide 6 Could no	4 6 0	on of injuny - At	home farm		☐ Yes 2☐	_ INO	28f Locatio	n (Str	et and Nur	mher or Rur	ral Route Number,
Division or Vital Records,	or A	Certification:	4 ☐ Homicide determin	led bu	lding, etc. (Spe	cify)	, street, factory, offic			City or	Town,	State)		
	Hospital or Attende 14 hours after death Funeral Director: (tely filled in by the		29a. Certifier 1 Certifying	Physician: To	he best of my k	knowledge, d	leath occurred at the	time, date a	and place	e, and due to	the ca	use(s) and	manner as	stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	(Check only 2 Medical E		basis of exam anner stated.	ination and/	or investigation, in m	y opinion, de	eath occi	urred at the tir	ne, da	te and plac	e, and due	to the cause(s)
	To the within 24	Me	29b. Signature and title of certifier				29c. Lice	nse number	1		29	d. Date sign	ned (Month	, Day, Year)
				MD			D.	7 14	7 1		J	1001	25	7007
	ın			ho completed ca	use of death (I		pe, Print)	(an	0	ator	150	010	M61.	1 londi
	10		21 Data filed (Marka Day Year)	32	11	1.000	1 01010	-11	c /	-11 4 1		. 1	1 . 1	

Registrar

APR 2 7 2007 32 egistrar's Signature

		1 - For State Registrar	State of	Maryland / De _l	partment of F e <i>rtificate of</i>			jiene 0	7 13597
Physic /Med		Decedent's Name (First, Middle, La: Henry Walter Rap					2. Date of Dea Month April		3. Time of Death 5:00 AM M
Exami		4a. Facility Name (If not institution, giv 201 Mt. Vernon P		oer)	4b. City, Town, o	Rockvill		4c. County o	
Funeral Director		5. Social Security Number 6. S 218-34-7087	ex 7. M 2□ F	Age (In yrs. last birthda 84 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 03/12/	Year) 1923	9. Birthplace (State or Foreigr Country) MA
Maryland a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County	nery	10c. City, Town or Rockvil					10d. Inside City Limits 1 □ Yes 2 No
h with the 23a or 28	Funeral Director	10e. Street and Number 201 Mt. Vernon P.	lace		10f. Zip Code 20852	_	1	Og. Citizen of Wi	
DESIGNOFE, IMBRYIBING Z I Z I 3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat has notified at any since.	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Amed Forc 1 Yes 2 If Yes, Give Year or Date	es?	B. Was Decedent of If Yes, specify Cub	an, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No-	Black	- American Indian, , White, etc. White
Z1Z15-UU36 Id within 72 hours at giene. In them "neture!; or them "neture!; or them "neture!; or them "neture!; or them "neture!; or the Medical Every	Completed	15. Decedent's E. (Specify only highest gra		(Gi	cedent's Usual Occup ve kind of work done . DO NOT use retire ctronic E	during most of work d)	king	16b. Kind of Bus Federal	iness/Industry Government
Maryland Z d 2 should be filed in and Mental Hygis th and Mental Hygis 7 le marked other traumatic event, II	To Be Co	17. Father's Name (First, Middle, Last, Ignac Rapalus)			18. Mother's Nam	ne (First, Middle, a Wcisto)
and 2 sho eelth and I n 27 is mo		19a. Informant's Name/Relationship (Jennie Rapalus/Wi	•	201	iling Address (Street Mt. Vern		Rockvil	le, MD 2	0852-
altimore, mit. Pages 1 at partment of Hee portant: if item y injury or othe	l N	20a. Method of Disposition 1 ☐ Burial DC Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	ate cemetery, c	position (Name of rematory or other place ake Crema	tory	Apr 26 2007	Beltsvil	City or Town, State
Departing Depart		7	meum	M0038Z	22. Name and Addre Rapp Fune: 933 Gist	Ave. Silv	er Spring	, Maryla	nd 20910-
The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the law requires that the purial-transit certification and certificatio		23a. Par1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Rena1 Due to (or Conge b. Anemi	railure rasa consequence of): estive Heart as a consequence of):					Approximate Interval Between Onset and Death
thet the death certific ed by the attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birt	nt at time of death	B Ectopic pregnanc	у		23d. Date Mont	,
w requires thet in the second by should be detailed.		Part II. Other significant conditions of	ontributing to dea	th but not resulting in the	underlying cause gr	ven in Part I.			oute to the cause of death?
	Completed						24a. Was a autops perform	med? de	ere autopsy findings available for to completion of cause of ath? Yes 2 \(\) No
ysician: The lis certificate had director, page	o Be	25. Was case referred to medical examiner? 1 Yes No	Hospital:	patient 2 ER/Outpat	ent 3□ DOA Ott	200	th (Check only or		(Specify)
ਹ ਵਿੰਜ਼	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	n		of 28c. Inju			ow injury occurre	· · - · ·
To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the funeral	Certification:	3 Suicide 6 Could not b 4 Homicide determined	building	f Injury - At home, farm, , etc. <i>(Specify)</i>			City or Tow	n, State)	r or Rural Route Number,
To the Hospital or within 24 hours efter to the Funeral Direction completely filled in I	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exar one)	nysician: To the bas miner: On the bas and manne	est of my knowledge, de is of examination and/or r stated.	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	, and due to the c rred at the time, d	ause(s) and man late and place, ar	ner as stated. nd due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of entifier	n,	0	29c. Licens	59 7 9 00 59 7 9		29d. Date signed	(Month, Day, Year)
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St Regist	ate trar	31. Date filed (Month, Day, Year) APR 2: 7 2007	A.	gistrar's Signature	A	,			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 16b per fh 9866 4-27-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 20 AM 4 67 Kv. d SSe /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility_Name (If not institution, give street and number) Examiner 9 A 0 OUSE Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax **Funeral** 10M 20 F Min Months Days Hours 244-44-4480 Usual Residence of Decedent Director with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State r than "naturel", or iteme 23a or 28e-f ehow the Medical Examinar must be notified at 1 Tes 2 No Director LTD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 21205 2000 Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No / Specify þ JLAC 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry
Home Improvement 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SEL traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any light yor other traumatic event size. 17. Father's Name (First, Middle, Last) Be BARBARA DSEP/H 255EL 406/1 ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6 105EpH 20b. Place of Disposition (Name of ERTOL BALTE, MID Date 9 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Peremation 3 Removal from State 2507 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Liceny 22. Name and Address of 2829 BAL MD. TO Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or or mr loations that caused the death. Pshock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician 5 mouths ~ 0 /Medical Due to (or as a conseduence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to for as a nonsequence of) Examiner physicien and s the buriat-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> page 2 should be 1€ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diractor: After this certificate has I in by the funeral director, page 2 s autopsy 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one | examiner Hospital: Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c 28d. Describe how injury occurred Injury at Work? Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier 29c. License number 2688 0 grue and address of person occompleted cause of death (Item 23a) (Type, Print) 300 Armor arris

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item/7 Per Ana Rd C368 6/14/07 Th
Department of Health and Mental Hygiene

State

Amend #5 Per INF C867 5/29/06 rdf Cate of Death For State Amend #5 Per INF G867 5/29/07 JH Registrar Amend #1 Per Phy C868 6/01/07 JH #8 ertificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 **Physician** April 12, 6:28 PM M John Ryer John Jerone Ryer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3526 St. James Road Randallstown Baltimore 5. Social Security Numbeunk Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1**∑**M 2□F 65 Yrs. 219-40-3701 Apr 15, 1942 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√ No Director MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 3526 St. James Road USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: Specify:white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education unk unk (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Joseph Ryer Zona Freed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Shpak/sister 602 N. Victoria Road MH 128 Donna, TX 78537 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 X Other (Specify) in state 21. Signature of Euneral Service Licensee Ropald S. Wade, 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street Approximate Interval Between Onset and Death 23a. Part Enter the disease, or com shock or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arterio school Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE Year Pa death? ģ Unknown Completed available cause of 25 Be 27 Certification: mber

ed by the ettending physicien and detached for use as the burial-transit The faw requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by to d be detach cete hes been sig , page 2 should b certificate has this ours efter death.
neral Director: A
filled in by the fu ŏ To the Hospital c within 24 hours of To the Funeral D completely filled in

Funeral

Director

27 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

72 hours after

should be

Heelth Item 27

permit. Pages 1 Depertment of H Importent: If Ite any Injury or ot once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 □Ectop	c pregnancy (specify)		Month Day
Part II. Other significant conditions or	ontributing to death but not res	ulting in the underlyi	ng cause given in Part I.		co use contribute to the cause of
				24a. Was an autopsy performed	24b. Were autopsy findings prior to completion of death? No 1 Yes 2 No
25. Was case referred to medical examiner? 1 № Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Othor	ath (Check only one)	e 6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how	injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h- building, etc. (Specif	ome, farm, street, fac y)	ctory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Nu State)
29a. Certifier 1 Certifying Ph	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occur tion and/or investiga	red at the time, date and plac- tion, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as stated. and place, and due to the cause
29b. Signature and title of certifier			29c. License number	29d.	Date signed (Month, Dey, Year)

DOOD 7632

04-18-07

MD

21222

BALTIMORE

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 2 7

M. Crossan O Donoran, MD

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.CROSSAN O'DONOVAN 3. Registrar's Signature

2112 DUNDALK AVE.

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		1 State	ate of Ma	aryland / l	•	tment of H <i>ificate of I</i>	lealth and M			0007	10000
		Registrar 1. Decedent's Name (First, Middle, Last)			Certi	ilicate of i	Jealii	2. Date of De	Reg. No. ath	2007	3. Time of Death
Physici /Medic		Wilbur Rose						April	Day 20	2007	16:12 PM
Examin		4a. Facility Name (If not institution, give street		1 6		4b. City, Town, or	Location of Death		4c.	County of Deat	h
Funeral		Johns Hapkins Boyvieu 5. Social Security Number 6. Sex) Medl	e (In yrs. last bi		If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	9. Birt	hplace (State or Foreign
Director		222-10-9746 ^{1⊠M 2}	Months Days Hours Min. (Month Days) 4 0 3 4 Co.								irginia
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Loca	ation					10d. Inside City Limits
Mary a-f sho	tor	MD Baltimore	MD Baltimore Ess								1 ∐Yes 2 x ∏ No
ite, INGI yial to ZIZIS-DOOSO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code			_	zen of What Co	untry?	
eath v ns 23a must	Funeral	916 Lance Avenue	as Decedent	Ever in U.S.	13. Wa	21221	ispanic Origin? (Spe	ecify Yes or No	US.	A 14. Race - Ame	rican Indian,
after d or Iten niner		1 ☐ Never Married 2 ☐ Married 1	med Forces? 2 Yes 2 ☐ I Yes, Give			Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)		Black, White	
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d be file	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name					
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and 2 sealth ar n 27 ls		Shanan Rose /so	n				g Avenu		-		
Pages 1 and of He ant: If Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove	al from State	cemete	ery, crema	tion (Name of atory or other place	ce)	Date		cation - City or	
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partilliore, Mappennit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other training.		21. Signature of Funeral Service Licensee	٠	1			y Funer				to. MD
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cal	ns that caus to	he death. Do						LESSE	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Esch	emic .	Bow	el					Onset and Death Three dates
/Medical Examiner		resulting in death)	Due to (or as	a consequence	0						
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ath cert	an/M			pf pregnancy 2 Fetal deat	th 3□E	Ectopic pregnanc	y		2	23d. Date of de Month	livery Day Year
the at	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)									
The law requires that the death The law requires that the death Ite has been signed by the atter agge 2 should be detached for u	by Ph	Part II. Other significant conditions contribu	ting to death b	out not resulting	in the unc	derlying cause giv	ren in Part I.	23e. Did tobacco use contribute			the cause of death?
iaw requires as been sign					-			Yes 2 No 3 Probably 4			robably 4 □Unknown
e law r has be e 2 sh	Completed							24a. Was	psy	prior to	utopsy findings available completion of cause of
VICAL FILE		25. Was case referred to medical					00 Plans of Para	1□ Yes	ormed? 2/10 No	death?	2 No
ys dir	To Be	examiner? 1 Yes 2 No	al: Inpati	ent 2 ☐ ER/C	Outpatient	3□ DOA Oth	26. Place of Deat ler: 4 □ Nursing Ho			6 □Other (Spe	ecify)
Ing Ph		1 X Natural 5 ☐ Pending	la. Date of Inju (Month, Da		Time of Injury	28c. Inju		28d. Describe	how injur	y occurred	
Vitending death. ctor: Afte	ficati	2 Accident investigation 3 Suicide 6 Could not be determined	e. Place of in	jury - At home, t	farm, stree	M 1 □ et, factory, office	Yes 2 No	28f. Location (Street an	d Number or R	ural Route Number,
tal or safter	Certification:	4 ☐ Homicide determined	building, e	tc. (Specify)				City or To	wn, State)	
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical	29a. Certifier Check only 2 Medical Examiner:	On the basis	of examination a							
o the vithin 2 omple	Med	29b. Signature and title of certifier	and manner s	ated.		29c. Licens			29d. Dat	te signed (Mon	th, Day, Year)
- > - 0	AFRIL 23, 20								, 2007		
10		30. Name and address of person who comple	ted cause of	death (Item 23a) (Type, P	Print) 494	O EASTE	RNA	VEHI	JE .	dia
Str	ate	31. Date filed (Month, Day, Year)	32. Rains	ar's Signature		SAL	TIMORE	MU	21	224	
Regist		APR 2 7 2007	E A	we to	P	seed 3					

		•	For State Registrar	State of Marylar		artment of H			ene 007	13601	
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death	
	Physici: /Medic		Victor Hugo	Robinette				April 24	Day Year 1, 2007	9:58 am ^M	
	Examin		4a. Facility Name (If not institution, give si			4b. City, Town, o	r Location of Death		4c. County of Deal		
			564 Chalcot Square			Essex			Baltimor	re	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	9. Birt	hplace (State or Foreign	
	Director		226-16-2823	M 2□F 88	Yrs.	Worth's Day's	110013	July 18,	1918 Vi	rginia	
	and ■	1	Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	cation				10d. Inside City Limits	
	fanyli sho	5				oution.				1 ☐ Yes 2 📉 No	
	28a-	Director	Maryland Baltimore	ES:	sex	10f. Zip Code		100	g. Citizen of What Co		
	with be o	ā								outling ?	
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	r iten	Funerai	1 ☐ Never Married 2 ☐ Married	Armed Forces?	'	f Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Whit		
ဗ္ဗ	el', o		3 ∰ Widowed 4 ☐ Divorced	If Yes, Give	942 945	I□Yes 2□XNo	Specify:		Specify:	ite	
Ģ	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23a or 28a-f ehow fra Madical Examinar must be notified at	Completed by	15. Decedent's Educ	ation	16a. Deced	ient's Usual Occup		16	6b. Kind of Business		
2	Pan "r	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	during most of work d)	king			
2	or th	20	7		Machi	ne Operat	or		Steel Mil	1	
B	be filed tal Hygid d other	Be (17. Father's Name (First, Middle, Last)			_	18. Mother's Nam	ne (First, Middle, Ma	aiden Sumame)		
S	should bind Ment	ို	Charles Walker	Robinett	te		Sylvia	Eugen	ne Ram	ey	
ם	and and is m		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	g Address (Street	and Number or Rui	ral Route Number, (City or Town, State, a	Zip Code)	
2	s 1 and 2 should be filed within 72 hours after death with the Marylan if Heelth and Mantal Hygiene if the firem 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Exeminar must be notified at		Ronnie Robinette	(Son)	564	Chalcot S			yland 212		
9	0 0		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Re	1	Place of Dispo cemetery, cren	sition (Name of natory or other plac	(9)	Date 20	Oc. Location - City or	Town, State	
Ë	tant:		4 ☐ Donation 5 ☐ Other (Specify)	Mea		ge Memori			Elkrid e	Maryland	
Baltimore, Maryland 21215-0036	permit. Pag Department Important: i eny injury o		21. Signature of Funeral Service License		22 R	Name and Addre	ss of Facility] Home DA			
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9	The law requires that the death certificate be executed sie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	edic	0.								
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregr		- ·			23d. Date of de	livery	
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Ě	The I	Completed						autopsy performe 1 Yes 2	ed? death? ∑No 1 ☐ Yes	completion of cause of	
ita	ician: Th certificete ector, pag	Bec	25. Was case referred to medical				26. Place of Dear	th (Check only one)	21	2010	
>	Physician: rthis certific ral director,	To	examiner? 1 ☐ Yes 2X No	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 Nursing H	ome 5 Residen	ce 6 XOther (Spe	Son's ^{cify)} Residence	
0	ng Pl		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe how	injury occurred	1100200100	
0	endir eath. or: A	atic	2 Accident investigation				Yes 2 □No				
Division of Vital Records,	if or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,	
Q	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.										
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edicai	(Check only 2 Medical Exemin	cien: To the best of my kn er: On the basis of examin	owledge, death ation and/or in	occurred at the tir	ne, date and place, pinion, death occur	and due to the cau	use(s) and manner as e and place, and due	s stated. to the cause(s)	
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens					
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	142		004-000	, , ,	37	リゾ	1 00 23		4-24	10)	
	NJ,		30. Name and address of person who cor				. Do	Nole W		21227	
	Sta	te	Dr. Sohail Quar 31. Date filed (Month, Day, Year)	12 1224 C		Avenue	e kosec	dale, Ma	гутапа	21237	
	Registr		ADD 9 7 200	- Maria	OF ASSE						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, 2. Date of Death Month **Physician** 0 sen 2007 20AM **/Medical 4c. County of Death City, Town, or Location of Death Examiner Rand Bal Kandall S

If Under 1 Year If Under 24 Hrs.

Months | Days 05 imore 101 town Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (in yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🛣 F Days Hours Min Yrs 213-38-6612 **Director** 66 07/23/1940 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural", or items 23a or 28a-f sho dical Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2 I TYLER FALLS 21209 <u>U</u>SA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE þ Specify 3 ☐ Widowed 4 💆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry uth and Mental Hygiene.

27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BENEDICT **BERMAN** MARIE CAPLAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trauonce. TERRI DORAN / DAUGHTER 8 HIGH SIDE COURT, OWINGS MILLS, MD 20b. Place of Disposition (Name of BNAT ISRAEL CONGREGATION 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 04/25/2007 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebrovasc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and the limit documents of the limit documents. See the limit documents are sulfing in death) Last Physician/Medical Examiner Due to lor as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-Division or Vital Records, P.O. Box 68760. attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown has been signed 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform certificate ha 1∐ Yes 2 **Z** No 25. Was case referred to medical To Be 26. Place of Death (Check only one) Subacute Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours at To the Funeral Completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature/and title of certifier 29d, Date signed (Month, Day, Year)

Registrar

State

APR 2 7 2007

Me

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Year)

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31. Date filed (Month, Day,

154010[d Co U

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

62912

Road Randallstown

32007

			1- State of Maryland / State of Maryland /	Department of Hea Certificate of Dea		ental Hygiene Reg. No				
26	observation of the state of the		Hegistrar 1. Decedent's Name (First, Middle, Last)	00100.10 020		2. Date of Death	3. Time of Death			
100	Physicia		William A. Stilling			APRIL 2		6:20F M		
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc	ation of Death		County of Death	imore		
		Į.	Saint Joseph Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last b				place (State or Foreign			
	Funeral Director		5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last b		lours Min.	8. Date of Birth (Month, Day, Year, July 13, 1) Cou	ntry)		
	ъ		Usual Residence of Decedent			10, 1				
	arylar show	_	Tou. State	vn or Location				10d. Inside City Limits 1 ☐ Yes 2X No		
	the M	ecto	Maryland Harford Bel Ai	10f. Zip Code		10g. Ci	itizen of What Cou	ntry?		
	3a or	iO IE	803 Dora Place	21014		U.S.	Α.			
	death	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 🏹 Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 🔯 Divorced Year or Dates:		pecify:		Specify:Whit			
Maryland 21215-0036	2 hour	ted to	15. Decedent's Education 16	a. Decedent's Usual Occupation	n	16b. F	Kind of Business/Ir	dustry		
215	thin 72 e. an "na Media	nplet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done durin life. DO NOT use retired)	ng most of workir		1	**		
2	led wi			nief Clerk	Mother's Name	Long (First, Middle, Maide	gshoremar	iUnion		
and	d be fill ed oth) Be	17. Father's Name (First, Middle, Last) Jospeh E. Stilling		ora E.		n Sumame)			
aryl	should nd Me mark mark	은	19a. Informant's Name/Relationship (Type. Print) 19	b. Mailing Address (Street and	Number or Rura	l Route Number, City	or Town, State, Zi	o Code)		
	and 2 ralth a 27 is	13		05 Chestnut Hi		est Hill,				
ore	ges 1 st of He If item or oth		1 N Rurial 2 Cremation 3	of Disposition (Name of ery, crematory or other place)			_ocation - City or T			
Baltimore,	t. Pag rtment rtant:		4 □ Donation 5 □ Other (Specify) Be1	Air MemorialGa 22. Name and Address of						
Bal	permit Depar Impor any fr once.		21. Signature of Funeral Service Licensee	Inc. 610 W.	DCII			e of Bel Air 21014		
И			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, so	uch as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)							
	Examiner			Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION						
	5 A	Jer	Se uentially list conditions, if any leading to immediate b.							
	ecuted ind	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. CORONARY AR							
8760,	ficate be executed physician and	E E	resulting in death) Last Due to (or as a consequence	e or):						
687	ficate physis the	edical	d							
Box	eath certific attending p for use as	M/u	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal dea				d. Date of delivery Month Day Year			
O. B	the death certifi y the attending I iched for use as	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month Day Yea			
Δ.	that the de ned by the a detached		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in	n Part I.	23e. Did tobacco	use contribute to	te to the cause of death?		
Records,	es De di	d by	SEVERE CARDIOMYOPATHY			1 ☐ Yes	bably 4 ☐Unknown			
000		Completed	PULMONARY EDEMA			24a. Was an	24b. Were aut	opsy findings available ompletion of cause of		
R	0 7 0	mo				autopsy performed? 1 Yes 2 X	death?	2 No		
Vital	sician: The certificate rector, pag	Be (25. Was case referred to medical examiner?		6. Place of Death	Check onl one				
or	Phys this al di	은	1			ne 5 Residence 28d. Describe how inj		ify)		
O	ing After une	tion	1 Natural 5 Pending 2 Accident investigation	Injury Work?	2 □ No		ary obtained			
Division	l or Attending after death. Director: After	Certification:	3 Suicide 6 Could not be 4 Homicide determined building, etc. (Specify)	farm, street, factory, office		28f. Location (Street a City or Town, Sta	and Number or Ru	ral Route Number,		
Ö	ital or Ars after ral Dire	Cert								
	To the Hospital or a within 24 hours after To the Funeral Direction completely filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, death occurred at the time, on and/or investigation, in my opinion.	date and place, ion, death occur	and due to the cause(red at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)		
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License nu	umber	29d. D	ate signed (Month	, Day, Year)		
			(undly tow !!!)	D24Ø3	14		1/24/	0.1		
	10		30. Name and address of person who completed cause of death (Item 23a							
	10	ato.	TIMOTHY LOW M.D. 76V1 OSLER 31. Date filed (Month, Day, Year) 32. Distrar's Signature	-	N, MAR	YLAND 21	204			
	Sta Regist		APR 2 7 2007 Brown &	Soule .						

			1 = For Amend :	Item 1 State of	Marylar dr., g86	6,0472	7/07dhb rtificate of L	ealth and M Death		ene 2007	13604	
	Physici /Medi		1. Decedent's Name (First, M	orey Swei	gart	5	weigert	•	2. Date of Death Month April	Day Year 23 2007	3. Time of Death	
	Examir		4a. Facility Name (If not institu	11 1 1	-		4b. City, Town, or	Location of Death		4c. County of Death		
ш		П	The John	6. Sex	Hospi		Baltin #Under 1 Year	If Under 24 Hrs.	ty	N/A		
ľ	Funeral Director		194-44-7121	1 ⊠ M 2□ F	7. Age (In yrs. 52	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y		place (State or Foreign ntry) ISYLVania	
	and *		Usual Residence of Deceden 10a. State 10b. Cou		10c Cit	ty, Town or Lo	cation				10d. Inside City Limits	
	Maryll	Į	PA Leba			anon	- Section				1 ☐ Yes 2X No	
	th the or 28a	Director	10e. Street and Number				10f. Zip Code		100	g. Citizen of What Cou	ntry?	
	ath wil	rai D	1604 Colonial	Circle			17040		Un	ited State	es	
9036	within 72 hours after death with the Maryland jiene. r than "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be nutilled at	by Funeral	11. Marital Status 1 ☐ Never Married 21 ≥ 1 3 ☐ Widowed 4 ☐ Divor	Armed Format 1 ☐ Yes Girl	2⊠No ve		Was Decedent of His f Yes, specify Cuban 1 □ Yes 2 ∑X Io	spanic Origin? (Spe i, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.	
Maryland 21215-0036	within ene. than *	Completed	15. Dece (Specify only high Elementary/Secondary (0-1	dent's Education ghest grade completed) 2) College (** 4		(Give	dent's Usual Occupat kind of work done di DO NOT use retired)	uring most of worki	ng	Sb. Kind of Business/Ir		
102	a the state of the	Be Co	17. Father's Name (First, Midd			Drug a			(First, Middle, Ma		nearch	
ylar	should be ind Mental marked c	To B	Carl Sweigart					Catherine	e Beck			
_	s 1 and 2 should f Heelth and Mer Item 27 is marks other traumatic		19a. Informant's Name/Relati Jayne Anne Swe		e)		ng Address (Street ar Colonial C			City or Town, State, Zij	Code)	
Baltimore,	Pages 1 and of He unt: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremati	on 3 Removal from	State	emetery, crer	sition (Name of natory or other place) !		c. Location - City or T	own, State	
Iţim	그 는 문구	1	4 □Donation 5 □Othe 21. Signature of Funeral Serv	r (Specify)	S.		1 Cremato	_	/2004 Wi	nfield, MI)	
Ba	Depermine Depe		1044	Men	-	Bur	rier-Quee	n Funeral		nd Cremator		
			23a. Part1. Enter the disease shock, or heart failure.	o, or complications that c List only one cause on e	aused the death	n. Do not en	ar the mode or dying:	Liberty I such as cardiac o	d Winfi respiratory arrest	eld, MD 21	Interval Between	
).	Physician /Medical		Immediate Cause (Finaf disease or condition resulting in death)		rhythm						Onset and Death	
Н	Examiner			Do	or as a consequence	uence of):					I week	
	ם א	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- V.	(or as a consequ						1 week	
	and III-trans	Examiner	that initiated events resulting in death) Last		rrhosi	uence of):					5 years	
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_	ertifica ding ph	a	fF FEMALE:			_						
P.O. Box	that the death certifined by the attending produced for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnanl at time of death 5 Other (specify)							23d. Date of delivery Month Day Year		
ds, F	e ig		Part II. Other significant cond	litions contributing to de	eath bul not resu	ulting in the ur	iderlying cause given	in Part I.	23e. Did tobac	cco use contribute lo t	ne cause of death?	
000	aw require s been sign	Completed							24a. Was an	/		
ž	The lav	Com							autopsy performed 1 ☐ Yes 2	d? prior to co death? ¶No 1 ☐ Yes	psy findings available impletion of cause of	
Vita	ysician: This certificate	Be	25. Was case referred to med examiner?	Hospital: 3				26. Pface of Death				
d	Phys r this ral dir	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatien 28b. Time of		4 Nuising Hon	ne 5 Residenc	e 6 □Other (Specificially occurred	y)	
<u>0</u>	Attending Physician: r death. ector: After this certifics by the funeral director, I	ation	1 Natural 5 ☐ Per 2 ☐ Accident inve		h, Day Year)	Infury	28c. Injury a Work? M 1 ☐ Ye	es 2 □No		mary occorred		
Division of Vital Records,	7 9 - 0	Certification:		uld not be ermined 28e. Place buildir	of Injury - At ho	me, farm, stre	eet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Rura State)	il Route Number,	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical C	29a. Certifier 1 Certification (Check only one)	fying Physician: To the cal Examiner: On the ba	isis or examinat	wledge, death	occurred at the time	, date and place, a nion, death occurre	nd due to the caus	se(s) and manner as s	(ated.	
	othe vithin 2 omple	Mec	29b. Signature and title of cert	and mani	ner stated.		29c. License r			Date signed (Month,		
	(Michael	Grunwald, N	ledical	Doctor	Rec.	-000		pril 23	2007	
	(((e)		30. Name and address of pers		e of death (Item	23a) (Type, I	Print)				laryland 21287	
	Star Registra	te	31. Date filed (Month, Day, Ye		egistrar's Signat		0		ne meet	, valunore, Ev	laryland elect	
			ELLY ()	JUI FARE WALL	SS.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #27&28a-i Per Phy G866 4/23/07 Jb Certificate of Death Red. No. 1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** April Laura Stephens 3, 2007 ±:00 AM /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🗹 F Sept 22, 517-28-3546 95 1911 Kansas Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2☐ No MD Montgomery Bethesda Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5215 Cedar lane 20814 USA 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife lown home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Chester Smith Erma Strachan ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 Magnolia Parkway Chevy Chase, MD 20815 Ralph Stephens/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 X Donation 5 ☐ Other (Specify) ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature | Funeral 5 tyice Licensee | Ward Director Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part . shock, Immediate use (Final disease or condition resulting in death) **Physician** sepsis /Medical Due to (or as a consequence of): CEMPCINON REPROPED BY MEDICAL EX Examiner chronic obstructive pulmonary disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed debility and as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏ Linknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by right hip fracture 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No anemia 24a. Was an autopsy perform this certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XX es 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 ☐ Pending investigation Injury 1 Tavatural 1 ☐ Yes 2 🗙 🗙 🔾 To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: A 3-25-07 Unwitnessed Fall 2XXAccident unknown filled in by the 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number of City or Town, State) 3563 4 ☐ Homicide Silver Spring MD. Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams Uniformed Services University Bethesda MD. 20814

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 3

32. Registrar's Signature

		1	For State Registrar	State of Mary		epartmen Certificate			Mental	Hygien Reg. N	131) 7	13606
Dhy	sicia		1. Decedent's Name (First, Middle, Las	_					2. Date of Month		ay 4	Year	3. Time of Death
/M	edic	al -	LINDA SCOT		232	27 Ab City	Town or Lo	ocation of De	4		c. County	07	12.13
Exa	mine	24	4a. Facility Name (If not institution, give Future Care Ch	- 120 1/11		arks.			more		,	/A	
Fune Direc			5. Social Security Number 6. Se		yrs. last birth	day) If Under Months	1 Year I	f Under 24 H Hours M	irs. 8. Date of	f Birth b, <i>Day</i> , Year —1968	r)	9. Birthpl Count MARY L	ace (State or Foreign try) AND
pug *	ev.		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Location						10	Od. Inside City Limits
Maryla f sho	200	ğ	MD. N/A			IMORE							1 X Yes 2 ☐ No
n the l		rec	10e. Street and Number			10f. Zip	Code			10g. C	itizen of	What Coun	try?
th wit	9	aiD	1520 W. NORTH AV	E. APT 302			21217				USA		
ite; IVIDITY INTO X I Z I D-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other then "neturel", or Items 23s or 28s-f show		by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	r in U.S.	13. Was Deced		anic Origin? Mexican, Pu <i>Specify:</i>	(Specify Yes of lerto Rican, etc	or No- .)	Bla	ce - Americ ck, White, e y: BLA	etc.
2 hou	100	ted	15. Decedent's Ed	ucation	16a. [Decedent's Usua Give kind of wo	al Occupation	on ina mast af v	warkina	16b.	Kind of B	usiness/Inc	dustry
ithin 7		Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of wo. life. DO NOT us		ing most or i	, o, n, n, g		MED	TOAT	
iled w tygier her th			-12- 17. Father's Name (First, Middle, Last)	-0		NURSES A		8. Mother's N	Name (First, Mi	ddle, Maide		ICAL	
should be filed within Mental Hygiene.	2	To Be	MAURICE JOHNSON	JR					TER C.				
and 2 should be filed with ealth and Mental Hygiene.	Bullan		19a. Informant's Name/Relationship (7 GENESTER DORSEY (ype, Print)	19b.	Mailing Address	(Street and	AVE.	Rural Route N APT 302	umber, City 2. BALT	or Town	State, Zip E, MA	_{Cod} 21217 RYLAND
s 1 and of Health item 27			20a. Method of Disposition		20b. Place of I	Disposition (Nar.	ne of ther place)		Date	20c.	Location	- City or To	wn, State
Pages nent of ent: If it	ury or		1 ☐ Burial 2 ☑ remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		CREMATO							IARYLAND
permit. Pages 1 a Department of Healinportent: If item	eny injury		21. Signature of Funeral Service Licen	1) Aus			7 N. I	MONROE	ST. DA	LTIM			AND 21217
Physic /Medi Examii	cal ner	ner	23a. Part1. Enter the disease, or component shock, in Pearl failure. List only immediate balse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	orsequence of V Pars	itive			shire y		,4		Approximate Interval Between Onset and Death
te be executed ysician and	e burian-trans	f any, leading to immediate cause. Enter Underlying Cause (Disease or Irijury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
VII.d. INECOLUS, F.C. BOX 00/00, icien: The law requires that the death certificate be executed certificate has been signed by the attending physician and	ached for use as un	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ⊟Ectopic pr 5 □ Other (sp						ate of deliver	ery Day Year
w requires that been signed b	IIQ De dett	þ	Part II. Other significant conditions of	5. 1	ot resulting in		ause given	in Part I.		Did tobacco		tribute to th	ne cause of death?
The law requested has been	age z snou	ompieted			··-				_	Was an autopsy performed?		prior to coldeath?	psy findings available mpletion of cause of
Cien:	ctor.	BeC	25. Was case referred to medical examiner?					-	Death (Check	only one)			
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Jing F	Tunera	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Ti	jury	28c. Injury a ?Work? 1 ∏ Ye		200. 0000	.100 11011 111	jary ooda		
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical.	completely tilled in by the funeral director.	Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 288 Place of Injury - At home, farm, street, factory, office 28f. Location								n (Street and Number or Rural Route Number, Town, State)		
e Hospite 24 hours e Funerel	letely tille	Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medicel Exam	ysician: To the best of miner: On the basis of ex and manner stated	amination and	death occurred Vor investigation	at the time, n, in my opin	, date and pl nion, death o	ace, and due to	the cause time, date a	(s) and m and place,	anner as s and due to	tated. the cause(s)
To th within To th	d woo	Me	29b. Signature and title of certifier	lu				537			4-	17-0	,
	2		30. Name and address of person who	completed cause of death	h (Item 23a) (Type, Print	jel A	hu,	Ralliz	m	M	021	2-17
Pe	Sta	-	31. Date filed (Month, Day, Year)	. Registrars	Signature	hade							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend#9,11,15-20c, 22,perFH,0867,5/3/07III

Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** 0626 John 2007 8 homas PNI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hospital Good Semavitar 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□F Sept 11, 1959 Maryland Yrs. 214-76-9414 47 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1√Yes 2 No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2301 pentland Drive 21239 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any injury or other traumatte event, the Mea Elementary/Secondary (0-12) College (1-4or 5+) Medical Technician Health Care unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be unkBetty Knight ပ Thomas Johnson 19b Mailing Address (Street and Number of Rural Route Number City of Town, State, Zip Code)
42.59 Steldon Avenue, Baltumore, MD 21236
5601 Loch Raven Blvd Baltimore, MD 21239 19a Informant's Name/Relationship (Type Print)

Betty Desirato Mother

Good Samaritan Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 5 Other in state 5/3/2007 Baltimore, MD 4 ☐ Donation Metro Crematory, Inc. C22 Name and Address of Facility Cremetion Society of More Inc. Tuneral Service Licensee , Director Baltimore, MD 2120121228 299 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2120121228 299 Frederick Road Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction

Due to (or as a consequence of): /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Tes End Stage renal disease Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Hypetension certificate has autopsy HIV 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

homes St. John

State Registrar

APR 2 7 2007

29b. Signature and title of certifier

David Weisman

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

H0059388

29d. Date signed (Month, Day, Year)

April 19,2007

State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death Rea. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** THOMAS VINCENT SANNINO APR 2007 4:46 P M 22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FORT MEADE ANNE ARUNDEL 8040-C ENGLE COURT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Min 1**X**M 2□F Months Hours 1940 Director 149-30-9679 July 6, New Jersey 66 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes X☐ No Directo Maryland Anne Arundel Ft. Meade the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Itams 23a 8040 C Engle Court 20755 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or Ital 1 Never Married 2X Married Yes 2 □ No fYes. Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. Specify À 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mineman Chief Petty Officer 12th United States Navy 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be 0 The 1ma Vincent DePaul Sannino Elizabeth Winchester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important; if Item 27 Is rr any Injury or other traurr 2002. Barbara J. Sannino/wife 8040 C Engle Court Ft. Meade, Maryland 20755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 C Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) West Arundel Crematory 4/25/2007 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, 21. Signature of Funeral Service Licensee Odenton, Maryland 21113 1411 Annapolis Road country (thomas Approximate Interval Between Onset and Death 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CANCER OF THE RIGHT TONSIL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown sate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🎇 No 24a. Was an certificate has 1 Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA SIL 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 25s Certifier 🗎 Gardying Physician: To the best of my knowledge, death occured at the time, date and place, and direct the cause(s) and marmer as stated Medical 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 01057843A (IN) 04/24/2007 Cold Dans Comp PhD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARMED FORCES INSTITUTE OF PATHOLOGY EDWARD L. MAZUCHOWSKI MAJ MC USAF ROCKVILLE MD 32. Registrar's Signature State 2007 Registrar

07-02986 Connor Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

PC 0: :	11116 111 -	MOIL ILIMOITATE			•
tate of	Maryland /	Department	of Health	and Menta	al Hygiene

2007 13609

		- For State Certificate of egistrar	Death	Reg.	
Physicia		L Decedent's Name (First, Middle,Last)		Date of Death Month I	3. Time of Death Oay Year 2010 hrs
Examin الديناوا		Connor Bryce Smith		April 18, 20	07 20101113
•	4	rail tubility Hamo (in fict motivation, give one of	b. City, Town, or Location of Deat Westminster	n	Carroll
		Carroll Hospital Center		n R Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr Months Days Hours Mi	n.	Foreign
Director		218-59-7234 1XM 2 F 6 Yrs.		Feb. 5	2001 Country)Maryland
		Usual Residence of Decedent 10a State 10b County 10c City, Town or Location	on		10d. Inside City Limits
Maryland 28a-f show any d at once.	- {	150. 50.0			1 Yes 2 X No
land f sho	5	Maryland Howard Glenelg	10f. Zip Code	100	. Citizen of What Country?
Mary Mary	Director	10e. Street and Number			
h the		14904 Triadelphia Road	21737 s Decedent of Hispanic Origin? (Jnited States 14. Race - American Indian, Black,
72 hours after death with the Maryland 72 hours after death with the Maryland 11 "natural", or items 23a or 28a-f sho 12 Examiner must be notified at once	Funeral	1 Nover Married 2 Married Armed Forces? If You	es, specify Cuban, Mexican, Puer		White, etc.
r deal	ᇍ	1 Yes 2 A No	Yes 2 X No specify:		Specify: White
s afte	à	or Dates:	t's Usual Occupation (Give kind o	f work done	16b. Kind of Business/Industry
hour "natt	ted	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use re	etired)	,
36 hin 72 e. than	흴		tudent		Elementary School
d with	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Nar	ne (First, Middle, M	aiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Timothy Kirk Smith	Donna	Gay1e	Krebs
	의	1001			per, City or Town, State, Zip Code)
MD nd 2 sho alth and m 27 is		11110 0119 1111 11111			lg, Maryland 21737
e, e, land 1 and 1		crematory or of	sition (Name of cemetery, her place)	Date	20c. Location - City of Town, State
MOI vages ent of out. It is		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: West Arund	lel Crematory 4/	21/2007	Odenton, Maryland
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr	ı	21. Signature of Funeral Service Li ensee	Name and Address of Facility onaldson Funeral	Home & (Crematory, P.A.
R F F F F F F F F F F F F F F F F F F F		M00773 141	1 Annapolis Roa	ıd Odento	on, Maryland 21113
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	he mode of dying, such as cardia	c or respiratory arre	
aminer		Immediate Cause (Final disease a. Cardiac arrythmia			Death
Calline		or condition resulting in death) Due to (or as a consequence of):			
	ايا	Sequentially list conditions, if any, leading to immediate b. Anomalous left main corol Due to (or as a consequence of)	nary artery		
	Ę	cause. Enter Underlying Cause			
=	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760, icate be executed physician and the burial - transit		d			
), be ex sician urial	Medical	X unpended #Z3a-b,27,perME, g866,	4/30/07 TT	_	23d. Date of delivery
760 Teate g phys		IF FEMALE: 23b. Was decedent pregnant in the 22c. If yes, outcome of pregnancy 1 Live birth 2 Fi	etal death 3 Ectopic pre	gnancy	Month Day Year
ox 68° eath certiff attending for use as	cian	past 12 months? 4 Pregnant at time of death 5	Other (Specify)		
30x death	S	1 Yes 2 No 9 Unknown 9 Unknown			
O. I at the d by th	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		obacco use contribute to the cause of death? S 2 ✓ No 3 Probably 4 Unknown
, P. res th signed signed be de	d by			_	
rds requi been hould	lete			24a. Was autop	prior to completion of cause of
e law e has ge 2 s	Completed			1 Yes	rmed? death? 2 No 1 Ves 2 No
FR F. Th tifical or, pa	ပိ	25. Was case referred to medical	26.Place of Death (Che	eck only one)	
/ita sicia is cer lirecte	o Be	examiner? 1 V yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other: Nu	rsing Home 5	Residence 6 Other:
of V g Phy her th	١ĕ	27. Manner of Death 28a. Date of Injury 28b. Time of	Injury 28c. Injury at Work?	28d. Describe	how injury occurred
OD On onding ath.	tio	1 A Natural 5 Pending	1 Yes 2 No		
ivisior I or Attend after death Director:	lica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Div ital or ral Div lled ii	Certification:	4 Homicide determined (Specify)		0. 10	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	을	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	urred at the time, date and place,	and due to the caus	se(s) and manner as stated.
To the within To the comple	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investig		ed at the time, date	
→ F.3 E.8	ğ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		Pat : (ania - Allolas	O.C.M.E.		April 19, 2007
	1	30. Name and address of person who completed cause of death (Item 23a)	444 Denn Chroni Dolli	nore MD 9490	21
		Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltir	HOIE, IVID 2 120	,,
	tate	31. Date filed (Month, Day, Year) \$2. Registrar's Signature			

			_ FOr	aryland / Der			d Mental Hy	giene	
			State Registrar	C	ertificate of	Death	0.0011.70	Reg. No. 2 0 0 7	-13610
¥	Physici	an	Decedent's Name (First, Middle, Last) NAME OF THE OF T				2. Date of De Month	Day Year	3. Tinhé of Death
	/Medic		4a. Facility Name (If not institution, give street and number)	.K	4b. City, Town, or	r Location of De	April	23, 2007 4c. County of Deat	3:30 p ^M
	Examin	ier	15611 Aitcheson Lane		Laurel	LOOKION OF E		Montgome	
-	Funeral	4		ge (In yrs. last birthda	y) If Under 1 Year	If Under 24 H	Hrs. 8. Date of Bir	th 9. Birt	thplace (State or Foreign
	Director		213-24-2896 1 M 2 K F	99 Yrs.	Months Days	riours	April		aryland
	pun 💉		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or	Location				10d. Inside City Limits
	//aryla	ō	Maryland Montgomery	Laurel					1 □ Yes 2 □ No
	the 1 28a-	rect	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	
	3a or		15611 Aitcheson Lane		20707	7		U.S.A.	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 10	B. Was Decedent of H	lispanic Origin?	? (Specify Yes or No uerto Rican, etc.)	14. Race - Ame Black, White	
92	or ite	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒️ If Yes, Give		1 □ Yes 2 X OXNo	Specify:	,	Coocifus.	
Ö	hours tura!"	Completed by	3 Widowed 4 □ Divorced Year or Dates:	16a De	cedent's Usual Occup	ation		16b. Kind of Business/	ite
75	in 72 n "nat ledica	olete	(Specify only highest grade completed)	(Gi	ve kind of work done . DO NOT use retired	during most of d)	working	Tob. Ring of Business	mastry
212	d with giene. rr thau	E	Elementary/Secondary (0-12) Grade 8 College (1-4or 9)		er-Operato	or		Soda Fou	ntain
b	e filed al Hyg I othe vent,	Bec	17. Father's Name (First, Middle, Last)					, Maiden Surname)	
<u>yla</u>	ould by Ment arkec	2	Charles Burton				Syndal		
lar	l2sh nand rism raum		19a. Informant's Name/Relationship (Type. Print)					per, City or Town, State, 2	. = .
e, l	1 and Healt em 2	12	Naomi Redmiles / daughter 20a. Method of Disposition		11 Aitches position (Name of rematory or other place		Date	, Maryland 20c. Location - City or	20707 Town, State
5	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heath and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show yr or other traumatic event, the Medical Examiner must be notified at		NXBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify)	·	iematory or other plac idge Mem I	1	27/2007	Elkridge,	
Baltimore, Maryland 21215-0036	그 두 후 후		21. Signature of Farrers Service Licensee		22. Name and Addre Donaldson				Maryrand
ä	Depar Impor any ir	is 3	I REAL IN					l, Maryland	20707
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death. Do not e	enter the mode of dyir	ng, such as car	diac or respiratory a	ırrest,	Approximate Interval Between
15	Physician			al Thrombo	sis				Onset and Death minutes
	/Medical Examiner		resulting in death) Due to (or as	a consequence of):	5				
	LXuiiiiici	<u>.</u>	Sequentially list conditions, b. Due to (or as	a consequence of):					
/X	nsit	Examiner	Cause (Disease or injury						
	execuna and ial-tra	Exal	that initiated events c c Due to (or as	a consequence of):					
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical	d						
9	ertifica ing ph e as th	Med	IF FEMALE;						
Вох	leath certific attending p	ian/	23b. Was decedent pregnant 1 Live birth	2 Fetal death	3 ☐ Ectopic pregnanc	y		23d. Date of de Month	livery Day Year
0	he de the a	Physician/Me	1 ☐ Yes 2 XX No 4 ☐ Pregnant a 9 ☐ Unknown 9 ☐ Unknown	it time of death	5 ☐ Other (specify) _				
<u>α</u>	requires that the de neen signed by the a hould be detached		Part II. Other significant conditions contributing to death b	out not resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco use contribute to	o the cause of death?
rds	w requires that s been signed it should be det	d by					_ 1□	Yes 2X No 3□Pi	robably 4 Unknown
Records,	N G S	Completed					24a. Was	an 24b. Were a	utopsy findings available completion of cause of
Ĕ	The law ate has b bage 2 sl	ШО					— auto perf 1□ Yes	ormed? death? 2 □X % 1 □ Yes	
/ita	ctor, I	BeC	25. Was case referred to medical examiner?				Death (Check only	one)	
or Vital	Physician: The la r this certificate has ral director, page 2	2	1 ☐ Yes 2XXNo Hospital: 1 ☐ Inpati			4 🗆 1401511		idence 6 □Other (Spe	ecify)
on C	ling Afte une	io ::	27. Manner of Death 12 Natural 5 Pending (Month, Day) 2 Accident investigation	ury 28b. Time ay Year) Injur	y Woi	ryat rk? Yes 2∐No	28d. Describe	how injury occurred	
Division	Attending r death. ector: After oy the funer	licat	3 Suicide 6 Could not be 28e. Place of in	jury - At home, farm,			28f. Location	(Street and Number or R	ural Route Number,
<u>≤</u>	al or A after 1 Dire d in b	Certification:	4 Homicide determined building, e	tc. (Specify)			City or To	wn, State)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f		29a. Certifier 1 Certifying Physician: To the best (Check only 2 Medical Examiner: On the basis of						
	the H iin 24 the F	Medical	and manner st						
	To the within To the comple	2	29b. Signature and title of certifier	. 1	29c. Licens			29d. Date signed (Mon	
	^		www.ww	dooth (Itam 00=) /T		13916		April 24,	2007
	3		30. Name and address of person who completed cause of william A. Warren, M.D. 32	death (Item 23a) (Typ 21 Prince		ceet L	aurel, Ma	ryland 207	07
	Sta	ate		rar's Signature					
	Regist	rar	APR 2 7 2007	- 1	1 3				

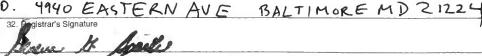
within 24 hours after death

To the Funeral Director;
completely filled in by the

State Registrar

LIPIKA SAMAL, M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

29c, License number

RF5-000

29d. Date signed (Month, Day, Year)

			For State Registrer	State of	Maryland /	Departr		Health and	Mental Hyo		007	13612
	Physic	ian	Decedent's Name (First, Middle						2. Date of Dea Month	ath	_ Year	3. Time of Death
	/Medi	cal		WALTER	SZYMANO				APRIL	25	2007	1618 นี
	Exami	ner	4a. Facility Name (If not institution					or Location of Deat			ounty of Death	
	Funeral		HARFORD MEM 5. Social Security Number	6. Sex 7	Age (In yrs. last b	irthday) If	Under 1 Year				RFORD 9. Birth	place (State or Foreign ntry)
	Director		216205300 Usual Residence of Decedent	№ 2 F	81	Yrs.	nths Days	Hours Min.	8. Date of Birtl 0 2 9 0 Pa)	/ 1992	MARY	LAND
	ehow	5	MD HAR	FORD	10c. City, Tov	wn or Location TE HA						10d. Inside City Limits 1 ☐ Yes 2 X No
2	the M	ectc	10e. Street and Number	CICD	WILL		of. Zip Code			ton Citino	n of What Cou	
3/6	death with the Maryland ms 23s or 28s-f ehow rmust be collined at	Funeral Director	4718 NORRISV				2116			Ţ	JSA	
)	after or its	þ	11. Marital Status 1 X Never Married 2 ☐ Marria 3 ☐ Widowed 4 ☐ Divorced	nied 1 📉 Yes 2	TATTAT T		es 2 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)		. Race - Americ Black, White, pecify:	
215-0036	within 72 hours ene. then "naturel", he Wedlen Exn	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed)	16a	a. Decedent's (Give kind life. DO N	Usual Occup of work done OT use retire	pation during most of word)	rking	16b. Kind	of Business/In	dustry
60%	filed wil Hygien other th	Con	12	0		ELEC	TRICI	AN		SPAF	RROWS	POINT
, DE	m - 0 5	Be	17. Father's Name (First, Middle,						me (First, Middle,			
_ (\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	hould be d Menta marked matic ev	2	JAMES SZYMA 19a. Informant's Name/Relations	ANOWSKI	10	b Mailin- Ad	dropp /Stropt	MA and Number or Ru		CHUI		0-4-1
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	and 2 sho saith and I n 27 is ma		FRANK SZYMANO					VILLE R				
Se.	- I & E		20a. Method of Disposition		20b. Place o		(Name of y or other pla		Date		tion - City or To	
\ E	it. Pages intment of intent: If it injury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1010		RY CE	1	0/07	BALT	IMORE	, MD
4 Balti	permit. Departitimport		21. Signature of Funeral Service	Licensee	A			ss of Facility CV				ERAL HOME 21237
PMES O	Physician and /Medical Examiner private transit	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unidening Cause (Disease or injury that initiated events resulting in death) Last	a. CORO Due to (o	used the death. Do ch line. The sa a consequence as a consequence as a consequence	AR7		ng, such as cardiac		est,		Approximate Interval Between Onset and Death
Box 88760,	eath certificate attending phy for use as the	Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d	ome of pregnancy h 2 □ Fetal death	n 3⊡Ecto	pic pregnancy	,		230	d. Date of delive	ery Day Year
S.9.	that the de ed by the detached	Phys	9 Unknown	9□ Unknow			12.00					
\mathcal{U}_{rrds}	aw requires that is been signed is should be detailed.	ted by		BSTRUCTI	VE PUL	MONA		en in Part I.		bacco use es 2□ñ		ne cause of death? pably 4 DUnknown
A NE	The law rate hes be	Comple	ATRIAL FIN	BRICATION	¥				24a. Was a autops perform	med?	24b. Were auto prior to con death?	psy findings available mpletion of cause of
7 ita	Physician: this certific al director,	Be (25. Was case referred to medical examiner?					26. Place of Dea	th (Check only on	/		
of	Physic this c	P	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inp		utpatient 3[4 Nursing H	ome 5 Reside			y)
~ F	ding h. After funer	ton	1 Natural 5 ☐ Pendin	9 '	Day Year)	Time of Injury M	28c. Injur Wor	yat k? Yes 2.⊠No	28d. Describe ho	ow injury o	ccurred	
Division	i or Attending after death. Director; Aftei i in by the fune	Certification: To	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of	f Injury - At home, fa , etc. (Specify)			163 2130	28f. Location (St City or Town		lumber or Rura	I Route Number,
	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director; After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physicien: To the b Exeminer: On the bas and manne	is of examination ar	e, death occi	urred at the tin ation, in my o	ne, date and place, pinion, death occur	, and due to the carried at the time, d	ause(s) an ate and pla	d manner as stace, and due to	ated. the cause(s)
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	F		30. Name and address of person DESH SHAM	who completed cause (MA, MD)	602 5.1	(Type, Print) HTWE	OD R	D. #10	6 BEL	- Als	am s	21014
	Sta Registr		31. Date filed (Month, Day, Year) APR 2. 7		istrar's Signature	Anach	25					

			1- State of M. State of M. Registrar	aryland /		artment of h		nd Mental H	ygiene Reg. No.	007	13613
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Schmic	Sta	Ler)		2. Date of I Month	1 Day 24,	Year 7	3. Time of Death 235 pm
	Examir	ner	4a. Facility Name (If not institution, give street and number) S. Social Security Number 6. Sex 7. Ag) / ge (In yrs. last	hirthday	4b. City, Town, o	or Location of D	re	0	of Death	hura
	Funeral Director		5. Social Security Number 6. Sex 7. Ag 218-56-2461 Cusual Residence of Decedent	44	Yrs.	Months Days		Min. (Month, May 2.	Birth Day, Yeer) B , 1962	Count	ace (State or Foreign ry) 'land
	e Marylan 3a-f show uilled at	ctor	10a. State 10b. County Maryland N/A	10c. City, To Balt						10	0d. Inside City Limits 1 X Yes 2 No
	th with the 23a or 21	al Dire	10e. Street and Number 4408 Adelle Terrace			10f. Zip Code 21229			11	of What Count ed Stat	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If Item 27 is marked other than "natural", or Itams 23e or 28e-1 show styr injury or other traumatic event, the Medical Examitter into the Instilled at ance.	by Funeral Director	11. Marital Status 11. Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 20 1 Yes 20 1 Yes 20 1 Yes 7 ive Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 X No	an, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	E	Race - America Black, White, e ecify: Whi	etc.
Maryland 21215-0036	I within 72 ho iene. r than *natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	5+)	(Give life.	tent's Usual Occup kind of work done DO NOT use retired Or Engine	during most of d)	f working		f Business/Ind in Mari	
/land	should be filed nd Mental Hygi marked other imatic event, t	To Be C	17. Father's Name (First, Middle, Last) Paul Schmidtchen, Sr.			_		Name (First, Midd Shirley M			
	and 2 sho eaith and I n 27 is me		19a. Informant's Name/Relationship (Type, Print) Mrs. Lynn Benach (Sister)		15 Ha	addington	Road,	or Rural Route Num Luthervi			
Baltimore,	Pages 1 ment of He ant: If Item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place ceme Evan:	of Dispo etery, cren S Fu	sition (Name of natory or other place neral Cha	pel Ac	Date 1711,29,2007		on - City or Tov	m, State Maryland
Bait	Dermit. Departi		21. Signature of Funeral Service Licensee		Pea 23	Name and Addre ACEful Al 25 York R	ss of Facility ternat load Ti	ives Fune monium, N	eral&Cre	mation 21093	Ctr.,P.A.
	Physician		23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each light mediate Cause (Final disease or condition	the death. D	,	End So l	g, such as car	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
鱖	/Medical Examiner	_	resulting in death) Due to (or as Sequentially list conditions, if any, leading to immediate Due to (or as Due to (or a) Due to (or as Due to (or a) Due t	a consequence	9601): 1211	Thron	3505.	ك			
760,	te be executed ysician and te burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	a consequence	ce of):	Vasc	uke	Acar	15t	-	
ox 687	death certificate I e attending physi d for use as the b	//Medical	IF FEMALE: 23c. If yes, outcome	of pregnancy					224	Data of dalice	
о. В	0 0 0	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1	2 Fetal dea	ath 3	Ectopic pregnancy Other <i>(specify)</i>				Date of deliver Month	y Day Year
Records, P.	The law requires that the de ite has been signed by the a bage 2 should be detached f		Part II. Other significant conditions contributing to death be	ut not resulting	g in the ur	iderlying cause giv	en in Part I.		l tobacco use co] Yes 2 □ No		cause of death?
al Reco		Completed	U					рег	s an 24 opsy formed?	b. Were autop prior to com death? 1 \(\sum \text{Yes} \) 2	sy findings available pletion of cause of
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	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only one) 2 Medical Exeminer: On the basis of and manner state 29b. Signature and title of certifier ()	examination a	and/or inv	estigation, in my of	pinion, death o	occurred at the time	, date and plac	e, and due to the	the cause(s)
	*		SC/SchO45			P53	250	>	1		
	10		30. Name and address of person who completed cause of de	tal	а) (Туре, I	o 0 /	Cerna	on bri	-e B	11/is	110
*	Sta Registr		31. Date filed (Month, Day, Year) 32. Hagistra	ar's Signature	do	espos					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 24, 2007 4c. County of Death Robert Louis Schnell April 8:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford Birthplace (State or Foreign Country) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 3 M 2 □ F Director 282-20-8768 82 Feb. 12, 1925 Ohio Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 □Yes 2 □No Directo Maryland Harford Fallston 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ğ g "natural", or items 23a 1401 Terry Way 21047 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Dates: Ţ 1 Never Married 2 Married Q4 | 07 20 / 0 Itimdre, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WWTT White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Coin Service Supervisor <u>Telephone</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Theodore Schnell Gladys Orilla Spahr ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 1401 Terry Way, Fallston, Maryland 21047

20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State <u>Hilda Schnell / Wife</u> 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ± ö Department of Important: If any Injury or once. 4 Donation 5 ☐ Other (Specify) Fallston UMC Cemetery 4-28-07 Fallston, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 23a. Part1. Ent. The 1 sease, or complications that caused the seath po not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic **Physician** year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural Intury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

Kevin 31. Date filed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29d. Date signed (Month, Day, Year)

D35012 April 26, 2007

NORTH AVE. Bel Air, Md. 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 24a per doc 8866 4-27-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Day 30 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** SIMKIN 2007 201054 APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕱 F Yrs 93 09/21/1913 Director 214-80-7358 MD Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyghene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 121 BRIGHTSIDE AVENUE 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed by 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **JACOB** PERNIKOFF BERTHA REHERT ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20 CABOT DRIVE, NASHUA, NH JAY SIMKIN / SON 03064 20b. Place of Disposition (Name of cametery crematory or other of CHOFETZ CHAIM CONGREGATION 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/24/2007 | BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, decomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 200 en disease or condition resulting in death) /Medical Examiner 200 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine nding physician and use as the bunal-transit the death certificate be executed Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the bunal Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 No 1 Umpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 8 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical License number

29d. Date signed (Month, Day, Year)

April 23 2007

April 23 2007 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hamelman

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 27

32.1

2007

gistrar's Signature

			1 - For State Registrar	State of M	aryland		artmen rtificate				1ental		ene () ()7	136	16
	Physici	an	Decedent's Name (First, Middle, Last) Edward Collinger								2. Date of		Day	Year	3. Time of	
	/Medi	cal	Edward Selinski 4a. Facility Name (If not institution, give s	treet and number)			4h City	Town or	Location of		Apri]	. 18	2007 4c. County	of Death	11:40	Дм
	Examir	ier	Joseph Richey Hosp				Balt:						N/A	or Death		
	Funeral		5. Social Security Number 6. Sex	7. Ag	ge (In yrs. la	st birthday)	If Under Months		If Under		8. Date of	f Birth		9. Birth	place (State o	r Foreign
	Director		220-22-7017	M 2 🗆 F	78	Yrs.	MOTILIS	Days	Hours		01/30				MD.	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation								10d. Inside Cit	y Limits
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	h with the 3a or 28a	Funeral Director	10e. Street and Number 1900 Thames St. Ap	t. 207	-l		10f. Zip 2123		_			100	g. Citizen of V	Vhat Cou	ntry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show may hours or other traumatic event, if a Mudical Exactif artifulation and DECE.	by Funer	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 7 Yes 2 If Yes, Give Year or Dates:			Was Deced f Yes, spec		spanic Origin, Mexican	gin? (Span, Puerto	ecify Yes o Rican, etc	r No-	Blac	e - Ameri k, White		
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Mary	d 2 should th and Men ?7 is marke traumatic		19a. Informant's Name/Relationship (Type Bertha Selinski /	e, Print) Wife			-						City or Town,			1
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Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License		3. 4.			_			•		lome at kridge			
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)ivisi	al or Attendi efter death Director: A d in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At hom c. (Specify)	e, farm, stre			es 2⊡ñ	-		on (Stre Town,		er or Run	al Route Numb	Der,
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	- > P 0		· MW	JUW.	MO			D41	476	5			04 -18	120	37	
	10		30. Name and address of person who con RNYMIND W. WILD P. M.	D. 6565	N CHA	RLU	Print) ST, Su	<i>U</i>			NORE,	MD			,	
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Educard Selunishi *11867 11:40am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23:04 1 **Physician** , 200 Marie 20 Turner Regina /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MIMORG 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/21/1919 Social Security Number 7. Ade (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1 □ M 2 🔀 F 87 DC 578-20-1827 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 TXYes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 819 N. Carey Street 21217 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛣 No Specify: à 3X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic 12 Pages 1 and 2 should be filed vent of Health and Mental Hygies ant: If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Wheeler Lucy Beans 19a. Informant's Name/Relationship (Type. Print) Great-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Turner/Granddaughter 819 N.Carey St.Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or or 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Mt.Carmel Cemetery 04/28/07 Baltimore,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Hm. 21. Signature of Funeral Service Licenses 108 W.North Ave.Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ardiops money disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and this is developed. Examiner and resulting in death) Last Due to (or as a consequence of) 68760 nding physician The law requires that the death certificate be Physician/Medical Box IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Ö 9 Unknown Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1□ Yes or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 4 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death / fter t 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury s after deu. •al Director: Alte •vv the fiv 1 □ Yes 2 □ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral (29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) 30. Name and address of person who completed 20 KEVIN-JEAN MCGANN 900 Year, egistrar's Signature

State Registrar

			1 - For Amend #9,16a	a&B,18&19a&B	d/Depa er Ana	artment of L Bd. G866 rtificate of	lealth ai Death	nd Mental Hy	giene Reg. No 200	7 13618
- W-	7 7	62	Registrar Decedent's Name (First, Middle, Last				-	2. Date of De	eath	3. Time of Death
Н	Physici		James Turley					Month April	14, 2007 Yes	11:55 AM ^M
15	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	r Location of		4c. County of D	
			Washington Adven	tist Hospital		Takoma I			Montgom	ery
	Funeral Director		230-42-124/	7. Age (In yrs. 77) 77	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Date of Bir Min. (Month, Da July 1	th Yea <i>r)</i> 9.1 2, 1929 Was	Birthplace (State or Foreign Country) Inington, Denk
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	Maryli f sho ied at	ō	DC		Wash.	ington				1 □ Yes 2√□ No
	28a-	rect	10e. Street and Number		Wabii	10f. Zip Code			10g. Citizen of What	Country?
	h with	Funeral Director	3238 13th Street	SE		200	32		US	A
	deat	ner	11. Marital Status unk	12. Was Decedent Ever in U Armed Forces?	.sunk 13.	Was Decedent of H	lispanic Origi	n? (Specify Yes or No	14. Race - A Black, W	merican Indian,
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notitied at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:		Specify: V	
S O	72 ho natur Jical J	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup	ation during most o	of working	16b. Kind of Busine	ss/Industry (317)
2	ithin ne. nan "	칕	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	d) 5	3	Televis	zi on
2	led w fygier her th	Š		nk	кет	pairman unk	10 Mothor	s Name (First, Middle		unk
Maryland	ould be fi Mental H arked otl atic ever	Be	17. Father's Name (First, Middle, Last,	,		unk				diik
ž	should tund Ment	ပ္	19a. Namey NPattanson	danohter	195442	554Sheldt	on "Ave	lancy Badco nue BALL	inore MD Thore MD	21206
Sa	d 2 s Ith an 17 is i		Washington Adver	ntist Hospital		,		e Takoma I	,,,	2 091 2
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 🕅 Other (Specif	Removal from State	Place of Dispo	osition (Name of matory or other plac	i	Date	20c. Location - City	or Town, State
Balti	permit. Page Department of Important; If any injury or once.		21. Signature Ronal Service user			2. Name and Addre tate Anato altimore.	omy Bo		Baltimore	Street
	Physician		23a. Part1. Enter the disease, or com shock, or neart failure. List only Immediate Cause (Final disease or condition	plications that caused the dear one cause on each line.		202 0350	-0.1 OSA(2-00-			Approximate Interval Between Onset and Death
8760,	Medical Examiner physician and the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect of the co	quence of):	ESSEL T	l In Hro	FARCTIC		•
.O. Box 68	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of o	aldeath 3[□Ectopic pregnancy □Other (specify) _	у		23d. Date of Month	delivery Day Year
Records, P.	uires that signed b Id be deta	þ	Part II. Other significant conditions of		sulting in the u	ınderlying cause giv	en in Part I.	23e. Did t		e to the cause of death? Probably 4 Munknown
<u>o</u>	w rec	lete		E RENAL D) 1 C = A	. C F		24a. Was	an 24b. Were	autopsy findings available
	: The law cate has	Completed	ANEMIA	AND COPS				auto perfo 1□ Yes	prior prior death 2 No 1 1	to completion of cause of n? 'es 2 No
Žį.	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:		nt 30 DOA Oth	er.	of Death (Check only		
Division or Vital	ding Phys n. After this funeral dir	ion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 27 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Injur	y at	28d. Describe	idence 6 Other (5 how injury occurred	Specify)
Division		Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 280 Place of injury - At h	ome, farm, st fy)				'Street and Number or wn, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical C		nysician: To the best of my knominer: On the basis of examinated and manner stated.		nvestigation, in my	opinion, deatl			
	To the l within 2 To the I complet	Me	29b. Signature and title of certifier	0		29c. Licens			29d. Date signed (M	
)			+ K. Jahr	Rao MI)	DO	039	255	04/16	107
			30. Name and address of person who Kuchibholta Sul	completed cause of death (Item	nton	MD 20	735			
	Sta Registi		31. Date filed (Month, Day, Year) APR 2. 7 200	32. Registrar's Sign	ature Span	W				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Richard F. Talley Sr. 04 5 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death osedale 1 timore SQUATE 8. Date of Birth (Month, Day, Year) March5,1950 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 216-52-3113 1 □M 2 □ F MĂryland 57 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore Parkville 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9115 Lamace Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Mo Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Lucent Tech 3Yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theodore Talley Sr. Phylis Lucas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon A. Talley /wife 9115 Lamace Road Parkville MD 21234 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Holly Hill Cemetery 4/30/07 Baltimore MD 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Suneral Service Licu see 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Parth. Enter the disease of complications that shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): THEROSCLEROS Due to (or as a consequence of): HYPERTENSION Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown contribute to the cause of death? 3 ☐ Probably 4 ☐ Onknown

Physician /Medical Examiner

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attending physician

Physician/Medical

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Certification:

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the Hospital or Attending Physician: The law requires that the death certificate be executed

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within 24 hours after death To the Funeral Director:

Division or Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

MD

Funeral

Director

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permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?
	1 ☐ Yes 2 ☐	No 3 Probably 4 Prohknown
	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2□No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

5 Pending investigation

6 ☐ Could not be

27. Manner of Death

1 Matural

2 Accident

3 ☐ Suicide

Hospital: 28a. Date of Injury (Month, Day Year)

and manner stated

1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed lise of death (Item 23a) (Type, Print) OOD FRANKLIN SQUARED TIVE BALTIMORE

1 ☐ Yes 2 ☐ No

State Registrar

MAEL 31. Date filed (Month, Day, Year) APR 2 7

29b. Signature and title of certifier

Registrar's Signature

			1_ State	arylan		partment of Healt Pertificate of Dea			0.0	10.7	10000	
	10.00		Registrar 1. Decedent's Name (First, Middle, Last)			, inouto or bou		2. Date of Dea			3. Time of Death	
16	Physicia /Medic		Lester Edward Wheele	у , Ј	r.			Month Apr.	24, 20	Year 0 0 7	6:30 P M	
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П	Funeral		1 ™ M 2□F		as <i>t birthd</i> ag Yrs.	/) If Under 1 Year If Un Months Days Hou	nder 24 Hrs. urs Min,	Date of Birth (Month, Day	, Year)	Coui		
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	er de	Funeral	11. Marital Status 12. Was Decedent Armed Forces?		S. 13	 Was Decedent of Hispanion If Yes, specify Cuban, Mex 	c Origin? (Spe xican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ace - Amerio ack, White,		
36	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or items 23a or 28a-f show kther the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	NO		1 ☐ Yes 2 【 No Spe	cify:		Spec	ify:	White	
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<u>Ş</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show sumatic event, the Medical Examiner must be notified at	2	Lester E. Wheeley, Sr.		1 401 14			otte Hau			0.43	
Maryland	d 2 sk th and 7 is n traun		19a. Informant's Name/Relationship (Type. Print) Mark S. Wheeley / Son		1	iling Address (Street and Nu 1 Seven Oaks					<i>'</i>	
	Heal Heal tem 2		20a. Method of Disposition	20b. P		position (Name of ematory or other place)		Date	20c. Location			
OE .	Pages ent of ht: If i		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Ponation 5 □ Other (Specify)	- 1		Park Ceme.	4/28	/2007	Baltimo	ore. N	Maryland	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic enone.	1	21. signature of Funeral Service Licensee	1 = 0 0		22. Name and Address of F		-				
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ŏ	death certific attending p	N/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth			B Ectopic pregnancy				ate of deliv		
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Division or Vital Records, P.O. Box	ires the signeral be d	Completed by Physician/M	CHRONIC OBSTRUCTIVE PULMO		-		art i.	1 □ Y			pably 4 Unknown	
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0	g Phy er thi	n: 70	27. Manner of Death 28a. Date of Inju	ıry	28b. Time Injury	of 28c. Injury at		28d. Describe h				
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	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examina	wieage, de tion and/or	am occurred at the time, da investigation, in my opinion	ne and place, n, death occur	and due to the red at the time,	cause(s) and i date and plac	manner as s e, and due t	stated. to the cause(s)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend #29d per ME 866 47/27/0 Penartment of Health and Mental Hygiene Registrar Amend25, perME, g867 5/10/07 TT Certificate of Death Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Howard Charles Walton 22 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMERE If Under 1 Year | If Under 24 Hrs. AGNES HOSPITAL SAINT . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Funeral Days Hours 1 XM 2 ☐ F Yrs. 216-28-8248 March 18, 1929 Maryland 78 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amortant: if item 27 is marked other than "natural", or items 23a or 28a-f show all jury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☑ No Directo Catonsville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 1414 Midvale Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 1951-55 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Master Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret V. Mullenberg Howard W. Walton, Jr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 213 Osborne Avenue; Catonsville, MD 21228 Mark K. Hilton Son-in-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Mem. Garden 4/26/2007 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature Funeral Service Lice ee 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATOM APPROVED BY MEDICAL ENGINEER Immediate Cause (Final disease or condition resulting in death) hema toma 9 hours **Physician** bdura /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) HOしのみを Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for TYPS 2 NO 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by metastotic orastote 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown has teen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an te 2 No 1□ Yes this certification or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation subject tell 11:45PM 21/07 1 ☐ Yes 2 X No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Baltimore, MD nome 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 47353 April 22,2007

ຸ State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

APR 2 7 2007

Baltimore, Maryland

21229

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Physician /Medical Examiner requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Examine

Physician/Medical

Be

Certification: To

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

the Medical

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, i

Completed by Funeral

Be

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

for page 2 funeral director, 24 hours after death. filled in by the

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

completely within 2

Hospital or Attending

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAMMEN 1500 Forest Glen Road, Silver Spring MD 20910

29d. Date signed (Month, Day, Year)

04, 12, 200)

29c. License number

60319

Registrar

APR 1 3 2007



				• •	epartment of Health and		
			1 - For State Registrar	•	Certificate of Death	Reg.	2001 13523
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	Physici /Medio		Mary Ellen	Albaugh		April 11,	2007 2:30 p M
2	Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dec		4c. County of Death
			Calvert County Nu		Prince Freder	S Date of Birth	Calvert 9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Se	344 (107) E	rs. Months Days Hours Mi	n. (Month, Day, Ye	Country) Maryland
			220-12-8346 Usual Residence of Decedent			Tracey //	
	show	_	10a. State 10b. County	10c. City, Town			10d. fnside City Limits 1 ☐ Yes 2 ☑ No
	89-1 s	ecto	MD Calver	t Princ	e Frederick	100	Citizen of What Country?
	with t	Funeral Director	10e. Street and Number		10f. Zip Code	, Tog.	
	ne 23	era	85 Hospital Road	12. Was Decedent Ever in U.S.	20678 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur	(Specify Yes or No-	U.S.A. 14. Race - American Indian,
ယ	or iter	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		erto Rican, etc.)	Black, White, etc.
21215-0036	d within 72 hours after death with the Maryland Jiene. r then "naturel", or items 23a or 28e-f show the Medical Examinar must be codified at	d by	3 Widowed 4 ☐ Divorced	If Yes, Give 22 Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: white
7	natu	Completed	15. Decedent's Ed (Specify only highest grad	ie completed)	Decedent's Usual Occupation 'Give kind of work done during most of w life. DO NOT use retired)	vorking 16t	b. Kind of Business/Industry
12	withir ene. then	E C	Elementary/Secondary (0-12)	College (1-4or 5+)	dietician		state hospital
	filed Hygi other	BeC	17. Father's Name (First, Middle, Last)			ame (First, Middle, Mai	
an	Aenta Aenta rked tic ev	To B	Harry McKinley	Wood	Jess	sie Cather	rine Eyler
Maryland	s 1 and 2 should be filed within 'f Health and Mental Hygiene. Item 27 Is marked other then 'f other traumatic event, the Mas		19a. Informant's Name/Relationship (7	ype, Print) 19b.	Mailing Address (Street and Number or	Rural Route Number, C	ity or Town, State, Zip Code)
_	and 2 ealth m 27	1	Kay E. Colie, gra		O. Box 181, Barsto		
ore	or off		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	cemeten	Disposition (Name of r, crematory or other place)	M	. Location - City or Town, State
Baltimore,	rt. Partmen		4 Donation 5 Other (Specify		33 Name and Address of Facility		ldersburg, MD
Ba	permit. Pages 1 and 2 Dapartment of Health a Important: If Item 27 It any Injury or other tra ance.		21. Signature of Funeral Service Licent	C	l I		ral Home, P.A.
			23a. Part1. Enter the disease, or comp	lications that caused the death. Do n	8325 Mt. Harmony ot enter the mode of dying, such as card	iac or respiratory arrest,	gs, MD 20736 Approximate Interval Between
	Physician		shock, or heart failure. List only of Immediate Cause (Final		(OF A17.45)	=RI DIF	Oncot and Doath
7	/Medical		disease or condition resulting in death)	Due to (or as a consequence of	SOFALZHFIME	-10) 013	72711
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	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	f):		
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760,	te be executed ysician and e burial-transit	cai E	l	4			
68	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	edic		V			
Box	h cert endin	N.	23b. was decedent priignant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery
-	e deat he att	sicie	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at time of death	5 Other (specify)		Month Day Year
P.O.	at the d by t letach	Completed by Physician/Medi	9 ☐ Unknown Part II. Other significant conditions or		the underking seven given in Part I	23e Did tohac	co use contribute to the cause of death?
Ś	signe signe d be o	ğ	Part II, Other significant conditions of	or a contract to the state of t	the underlying cause given in Fait i.	1 □ Yes	2 No 3 Probably 4 Unknown
Š	r requ	ete				24a. Was an	24h Wara autoney findings available
Rec	sician: The law certificate has l irector, page 2 s	Ę				autopsy performed	
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<u>></u>	Physician: rthis certific ral director,	To B	examiner? 1 Yes 2 10	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	Other	Home 5 Residenc	e 6 Other (Specify)
0	ng Ph Iter th neral	- E	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. T	me of 28c. Injury at work?	28d. Describe how	injury occurred
S	Attending r death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No		
Division of Vital Records,	or Att	Certification:	4 Homicide determined	28e. Pface of fnjury - At home, far building, etc. (Specify)	m, street, factory, office	City or Town, S	at and Number or Rural Route Number, State)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	S	29a. Certifier 1 Certifying Ph	vsician: To the best of my knowledge	death occurred at the time, date and pla	ice, and due to the caus	se(s) and manner as stated.
	24 hos Eur	edicai			Vor investigation, in my opinion, death of		
	To the within 2 To the comple	₩ W	29b. Signature and title of certifier	0 0	29c. License number	29d	Date signed (Month, Day, Year)
			I falsa H	Wengel is	026358	A	PRIL 12, 2007
	5		30. Name an odress of person who	completed was of death (Item 23a) (Type, Print)		ct. M)-20678
			31. Date filed (Month, Day Year)	WEIGE,	m) - PRINCE	1-10-DERI	CK. MJ-20618
	St: Regist	ate rar	APR 1	2 2007	14 Boart 1		

			For State Registrar	State of Mar		artment of F rtificate of			ienę/ U U eg. No.	1	13024
			1. Decedent's Name (First, Middle, Las	1)				2. Date of Deat Month		lane	3. Time of Death
	Physici /Medio		Sandra	В.	Barkin			April	10°, 200	7	1:23 A M
Such	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of	Death	
			Suburban Hospi			Bethes	sda If Under 24 Hrs.		Monte		
	Funeral Director			ox □M 2□F	(In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 6			ace (State or Foreign try) Land
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10	0d. Inside City Limits
	Mary f sho	ğ	Maryland Montgome	ery	Potomac						X□Yes 2□No
	r 28a	rec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	nat Coun	try?
	h witi	ai D	8807 Daimler Court	1		20854			U. S. A	۱.	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or iteme 23a or 28a-f show aumatic event, the Madical Examiner must be natilised at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver in U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black, Specify:	White, e	etc.
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup	pation during most of work d)	ina	16b. Kind of Busi	iness/Ind	lustry
2	Men.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)) 1			9	Mara a d m	. ~	
2	ited w Hygier Ther ti	S	17. Father's Name (First, Middle, Last)	5+	Reg	istered l	18. Mother's Nam	o /First Middle A	Nursir		
and	ntal he d	Be	Morris Snyder					Offit	vialuen Sumame,	,	
Ē	should ad Me mark matic	၉	19a. Informant's Name/Relationship (7	vpe. Print)	19b. Mailir	na Address (Street	and Number or Rur	a/ Route Number	City or Town. Si	tate. Zip	Code)
2	alth ar 11th ar 27 io		Dr. Gilbert D. Ba								
ē,	s 1 ar f Hea ltem othe		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place			20c. Location - C		
Ê	Page ent o nt: if ry or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Garden of			/2007 C	larksbur	g, N	Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 ie marked any injury or other traumatic ev		21. Signature of Funeral Service Licen	Stottle	Description of the property of	2. Name and Addre	ss of Facility -Goldberg Ville Pik	Memoria e. Rocky	l Chapel	ls, l	Inc. and 20852
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	ne grath. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arri	est,		Approximate
	Physician		Immediate Cause (Final		racerebra						Interval Between Onset and Death
	/Medical	:	disease or condition resulting in death)	a	consequence of):	I Hemolli	iage				
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, 20	oe exection a		resulting in death) cast	Due to (or as a	consequence of):						
68760	ificate be executed g physicien and as the burial-transit	edicai		d						-	-
P.O. Box 6	requires that the death certific een signed by the attending p hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date Monti		ny Day Year
	that led b	by Pr	Part II. Other significant conditions or	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	oacco use contrib	ute to th	e cause of death?
rds	quires n sign ald be							1 🗆 Ye	es 2.∭XNo 3	☐ Proba	ably 4 ∐Unknown
Division of Vital Records,	¥ 10 0	Completed						24a. Was a autops perforr	y pri ned? de	or to con ath?	psy findings available inpletion of cause of
a		e Co	25. Was case referred to medical				26. Place of Deat	1 Yes 2	Λ	Yes	2□ No
>	Physician: The la r this certificete has ral director, page 2	To B	examiner? 1 ☐ Yes 2X No	Hospital: 1 Anpatient	t 2 ☐ ER/Outpatier	nt 3 DOA Oth	0.5		ence 6 Other	(Specify	<i>(</i>)
on of	Attending Physician: ir death. ector: Atter this certificaby the funeral director.		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		f 28c. Injui Wor			ow injury occurred		,
Divisi	i or Atter after dea Director I in by the	Certification:	3 Suicide 6 Could not be determined		y · At home, farm, str (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number n, State)	or Rura	l Route Number.
_	Hospita 4 hours Funerel ely filled	Medicai C		ysician: To the best of liner: On the basis of e and manner state	xamination and/or in						
	To the within 2. To the I complet	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed	(Month, I	Day, Year)
			D 89				D0063195		April 1	11,	2007
	IV		30. Name and address of person who								
			Dr. Steven David	d Wilks 990)l Medical	Center	Drive, Ro	ckville,	Marylar	nd 20	0850
	Sta Registr		31. Date filed (Month, Day, Year)	32. Angistrar	's Signature	nerte					

Barkin, Sandra 4/10/07 1:23 A.m

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item per flh 869 7-13-07 vt. State of Maryland / Department of Health and Mental Hygiene 17

For Stete Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** April 7:00 A 4 2007 Claudine E. Bailey /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Manor Care Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 M 2 TKF Yrs Director May 3, North Carolina 94 03 - 9821Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the Health and Mental Hygiene ont: If item 27 is marked other than "naturel", or items 23s or 28s-f show 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 77 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at 1 X Yes 2 ☐ No Directo DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20002 1400 Florida Ave., NE #816 United States Funera 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ Negro 3 → Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 11thCosmetologist Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Lucious Smith Roland Knight 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Importent: If item 27 is eny injury or other trau once. 1400 Florida Ave., NE #816, Wash., DC 20002 Claudine E. Bailey/Self 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery 4/10/2007 * 4 ☐ Donation 5 ☐ Other (Specify) Ft. Brentwood, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee nn leval 4001 Benning Rd., NE Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherosclerosis heart disease years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒No 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) isigned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反Unknown should Failure to thrive Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? Yes 2 No this certificate 2□ No 1 ☐ Yes 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Cther: Value Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director: After the completely filled in by the funeral 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ungn D19609 April 11, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Rd., Ste. 202, Gaithersburg, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 3 2007 Registrar

e	Type or Print in Black Indelible ink. Ensure All Cop	ies .	Are	Leg	ID
	State of Maryland / Department of Health and Mental	Hyg	iene	20	0

1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 04 DALLAS KAYWOOD BRYANT 10 2007 10:54 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES 931 CHATSWORTH DRIVE ACCOKEEK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral 1**X**M 2□ F Months Days Yrs. Director 229 44 2262 69 03-17-1938 SUFFOLK, VA Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location Show 10a State 10b. County traumatic event, the Medical Examiner must be notified at 1 ☐ Yes X No MD PRINCE GEORGES ACCOKEEK Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 931 CHATSWORTH DRIVE 20607 Items 23a USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ō Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 X Divorced natural 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9TH MAINTENANCE ARMY CORP OF AMERICA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I JAMES F. BRYANT ROXIE EURE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I 1118 HORIZON VIEW PL, ACCOKEEK, MD 20607 SHELDON BRYANT/SON other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ¹X Burial 2 ☐ Cremation 3 ☐ Removal from State pernit. Page Depirtment of Important: If any injury or once. RESURRECTION CEMETERY 04-17-2007 ^¹ 4 □ Donation 5 □ Other (Specify) CLINTON, MD 22. Name and Address of FMARSHALLS FUNERAL HOME OF MD 21. Sign, ur of Funeral Service Licenses 4308 SUITLAND RD, SUITLAND, MD 20746 Approximate Interval Between Onset and Death 23a. P.M.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 1-2 HOURS ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 20 YEARS CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, RECURRENCE OF PROSTATE CANCER WITH LARGE BLOOD 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? LOSS CAUSING ANEMIA 2 X No SEVERE OBESITY WITH HYPERTENSION 1 Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b Time of Certification: Division 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death, 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) in by 4 Homicide pelli To the Hospital 24 hours 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 02237 arsin 11 MA APRIL 12, 2007 11 and U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD FARSON, MD., 10 ST. PATRICK RD, #203, WALDORF, MD 20603 31. Date filed (Month, Dav. Year)

State Registrar



Physician /Medical Examiner Box 68760

use as the burial-transit and be detached of Vital Records, P.O. certificate the funeral director. this After Division after death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after de To the Funeral Directo completely filled in by th

Physician

/Medical

Examiner

10a, State

MD

Funeral

Director

or 28a-f show

r than "natural", or itame 23a or 28a-f eho the Medical Exeminer must be notified at

filed within 72 hours after death

permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, Ina Media 2006.

Baltimore, Maryland 21215-0036

Direct

Funeral

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Completed

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	Sta Registr	

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Be 1 ☐ Yes 🏖 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending **∭**Natural 1 Yes 2 No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

#103

WALDORF,

JARIWALA MANISHA, Μ. D. 11637 TERRACE DR. 31. Date filed (Month, Day, Year)
APR 1 6 2007 32. Registrar's Signature

30. Name and/ dress of person who completed cause of death (Item 23a) (Type, Print)

07-02754 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lindsay L. Bender State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day April 11, 2007 Lindsay Bender Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Interstate 270 near Park Mills Road Frederick 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. **Funeral** 7. Age (In yrs. last birthday) Months Days Hours Min Director 166-72-5644 $_2X_F$ 25 1 M Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Pennsylvania Dauphin Harrisburg 28a-f show is marked other than "natural", or items 23a or 28a-f sho atic event, t<u>he Medical Examiner must be notified at once.</u> Director 10e Street and Number 10f. Zip Code 6809 Clubhouse Drive, Apt. G-3 17111 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Never Married 2 Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2XX No Yes 3 Widowed Divorced f Yes, Give Year Yes XX No specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nat
injury or other transmatic event, the Medical Exa during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Sale Representative 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Charles Jospeh Bender Be Michelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Jospeh Bender (Father) 203 Georgetown Rd., Mechanicsburg, PA 17050 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition X Burial 2 Cremation 3 Removal from State crematory or other place) Gate of Heaven Catholic Cemetery 04/17/07 Ponation 5 Other Specif erlyice Lideralided T. Lochstampfor 22. Name and Address of Facility Lochstampfor Funeral Home, Inc. 48 S. Church St., Waynesboro, PA 17268 Signature of Funera M00849 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complications that **Physician** failure. List only one cause on each line. /Medical Compressional asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an autopsy performed? After this certificate be funeral director, page ✓ Yes 2 To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Other; Inpatient 2 ER/Outpatient 3 Nursing Home 5 1 V Yes 28a. Date of Injury 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: within 24 hours after deam.

To the Funeral Director: A Apr 11, 2007 Passenger auto auto collision 0809 hrs Natural Yes 2 V No Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined

3. Time of Death 0816 hrs 4c. County of Death Frederick B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Pennsylvania 10d. Inside City Limits 1 Yes 2XXNo 10g. Citizen of What Country USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Furniture Weaver 20c. Location - City or Town, State Mechanicsburg, Pennsylvania Approximate Interva Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? Yes 2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes Residence 6 V Other: Scene 28f. Location (Street and Number or Rural Route Number, City or Town, State) Interstate 270 near Park Mills Road, Frederick, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) April 12, 2007

DHMH 17 Rev 1/2001 **OCME 2006**

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Zabiullah Ali, M.D.

31. Date filed (Manth Day Year

Medical

State

Registra

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

(Specify) Major Road / Highway

and manner stated

Assistant Medical Examiner

1 Marin

32 Registrar's Signature

and address of person who completed cause of death (Item 23a)

2007

			1 - For State Registrar	State	of Maryl	and / Depa <i>Cei</i>	artment of H rtificate of L	lealth and N D <i>eath</i>		giene 2 (07	13629
	-		1. Decedent's Name (First, Middle	e, Last)					2. Date of De		Vans	3. Time of Death
	Physici /Medio		Emma Rebecca I	BERGER					APRIL	Day 13 D	Year	8:34 AM
	Examir		4a. Facility Name (If not institution	n, give street and n	um <i>ber)</i>		4b. City, Town, or	Location of Death		4c. County	4c. County of Death	
			17531 Woodlawn	Drive			Hagerst	town		Wa	shing	ton
	Funeral		5. Social Security Number	6. Sex	7. Age (In)	vrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, Da	th av. Year)	9. Birthp	lace (State or Foreign
	Director		214-36-0472	1 □ M 2 💢 F	93	Yrs.	Wortens Days	110013	Oct. 1	2 1913	_	sylvania
	pg *		Usual Residence of Decedent 10a. State 10b. County		100	City, Town or Lo	postion				1	0d. Inside City Limits
	eho eho	2	Tod. State		100.	Oity, TOWN OF LO	Cation					1 ☐ Yes 21 No
	Ne N	Directo	Maryland Wash	ington		Hagerst						
	With t						10f. Zip Code			10g. Citizen of	What Coun	itry?
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "nature!", or itema 23a or 28a-f ehow event, i'ra Madical Examical must be notified at	Funeral	17531 Woodlawn			- 11.0		21740			USA	- I- d'-
	it de	n n	11. Marital Status	Armed F		n U.S. 13. \	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Pecify Yes of No Rican, etc.)	Bla	ce - Americ ck, While,	
36	l', or	by F	1 ☐ Never Married 2 ☐ Marr 3 🖫 Widowed 4 ☐ Divorced	If Yes, G			1□Yes 2¶ No	Specify:		Specif	y: Whi	t o
215-0036	ture.	ed	15. Deceden		outos.	16a Dece	dent's Usual Occupa	ation	.,	16b. Kind of B		
15	in 72	Completed	(Specify only higher	st grade completed		(Give	kind of work done of DO NOT use retired	during most of work	king	Too. Itilia of E	03110334111	203119
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	Hygid other	Bec	17. Father's Name (First, Middle,				Homemark	18. Mother's Nam	e (First, Middle			mc .
<u>a</u>		To B	George Daniel H	Hartman				Hatti	le Eller	Scott		
Maryland	d 2 should th and Mer ?7 is marke traumatic	_	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street a				State, Zip	Code)
	l and 2 leaith a im 27 is		Shirley Leather	man - Da	ughter	1752	7 Woodlav	m Drive.	Harers	town. M	d. 21	740
ē,			20a. Method of Disposition		20	b. Place of Dispo			Date	20c. Location		
Ë	Pages nent of int: if it ury or o		1 N Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		1	•	m Mem. Pa		107	Unnorat	or m	Maryland
Baltimore,	permit. Pages Department of I Important: if it eny injury or o		21. Signature of Funeral Service		4		2. Name and Address			Funeral		
ñ	Ped Ping		Of aligots	2020 L	7	4	15 E. Wil					and 21740
			23a. Part1. Enter the disease, or	complications that	caused the d							Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final	~			1 1					Interval Between Onset and Death
À.	/Medical		disease or condition resulting in death)			ACCULAV	R Accil	7547				EVENAL DAY
	Examiner				(3. 23 2 33							
		er	Sequentially list conditions, if any, leading to immediate	Due to	o (or as a cons	sequence of):						
	uted d ansit	בו	cause. Enter Underlying Cause (Disease or injury that initiated events									
ĵ	te be executed ysicien and le burial-transit	Examin	resulting in death) Last	Due to	o (or as a con:	sequence of):						
8/60	cate be executed physicien and the burial-transit	dicai		d								
B		Ф :		1								e :
X P	death certifi e attending id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pre		Ectopic pregnancy			23d. Da	te of delive	ry
_•	deat le att	100	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Preg	nant at time of		Other (specify)			Mo	onth	Day Year
j.	at the by th tache	ly S	9 Unknown	9□ Unk	nown							
ທົ	w requires that the death been signed by the atte should be detached for	by F	Part II. Other significant condition	ons contributing to	death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use con	tribute to th	e cause of death?
Ē	aquire en sle ould t		HYPERCIEWIO.	~, Asr	IAU	FIBRILL	-ATTON		1 🗆	Yes 2 No	3 Prob	ably 4 Unknown
Hecord	law reas be	piet	DENLITATED	Smil	5				24a. Was	an 24b.	Were autor	osy findings available
	0 5 0	Completed							auto perfo	ormed?	prior to cor death? 1 □ Yes	πpletion of cause of
		0	25. Was case referred to medical	1				26. Place of Deat			1 🗆 1 63	2 110
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 DOA Othe	AC .		dence 6 □Oth	er (Specify	0
	ding Phys Ih. After this funeral dir		27. Marvier of Death	28a. Date	e of Injury oth, Day Year	28b. Time of Injury	28c. Injury Work	at	-	how injury occur		,
<u></u>	Attending r death. ctor: After by the funer	atic	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	gation	m, bay rou	, injury		res 2 □ No				
JIVISION	r Atte	뜵	3 ☐ Suicide 6 ☐ Could reduced determined	ined 288. Plac	e of Injury - A	t home, farm, str	eet, factory, office		28f. Location (Street and Numb	er or Rura	l Route Number,
5	rs afte	Certification:			g, 0.0. (Op.				011) 01 10	on, Siate)		
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Certifyin	g Physician: To th	e best of my	knowledge, death	occurred at the time vestigation, in my op	e, date and place,	and due to the	cause(s) and ma	anner as st	ated.
	the F nin 24 the F			and ma	nner stated.				red at the time,			
	N To L	Σ)	29b. Signature and title of certifier	· /	11		29c. License	number		29d. Date signe	1	Day, Year)
1	AP,	10	1 buch to	& bo	der		7 33	1892		4/1	6/07	7
U	18		30. Name and address of person	who completed cau	of death (Item 23a) (Type,	Print) SULT	E 130	^	100	15	AGERSTOWN.
			TAM GLA POX	BRADI	DRV.	MA	11110 M	OVICAL	CATPU	r RA	M	1 2/742
	Sta		31. Date filed (Month, Day, Year)	9 0007	Penistrar's Si	gnature &						
-	Registr	ar	APR 1	(ZUU/)	Bilen	D. pop	N.S.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4: 00AM 4/14/2007 Phillip G. Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Williamsport Washington Homewood Nursing Home Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 € M 2 🗆 F 92 Yrs. 040124140 Director 8/3/1914 vt Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show mit: If item 27 is marked other than "natural", or items 23a or 28a-f show mry or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 XNo **Funeral Director** MD Washington Williamsport 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21795 16505 Virginia Ave Apt 302a USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Completed by 3€Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 4 <u>Administrative/Manager</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irwin Brown Ida Mae Chase ٩ 19b. Mailing Address (Street and Number or Rural_Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Virginia Doarnberger Magerstown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department o Important: If any Injury or Winchester, VA Omps Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rosedale Funeral Home Martinsburg, WV 25404 917 Cemetery Rd Martinsburg, 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmeriate Cause (Final **Physician** Renal Failure week discusse or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Vascular Disease Atheroscleratic vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or us a consequence of) Physician/Medical Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by heart tailure 3 Probably 4 □Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No periphera Vascular disease with below the 24a. Was an autopsy performed Knee amputation

25. Was case referred to medical examiner? 2 No To the Hospital or Attending Physician: Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Landursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director n by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined hours arter Swithin 24 hours a To the Funeral L 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cynthia Kutther-Sands mp D47451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

EVATA, a Kuttner-Sands no 17214 Paradise Church Road, Hagerstown Maryland

DHMH 17 Rev 1/2001

State

Registrar

Gynthia Kuttner-Sands, MD

APR 17 2007

31. Date filed (Month, Day, Year)

egistrar's Signature

			1- State of Maryland State of Maryland Registrar	Certificate of	Health and Mental F * <i>Death</i>	Reg. No.	1 10001
	6		1. Decedent's Name (First, Middle, Last)		2. Date of Month	Death C U U	3. Time of Death
	Physicia /Medic		Keina Marie Burrier		April	7, 2007	3:45 A M
	Examín		4a. Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of Death	4c. County of Dea	_
		ê a	2412 Kinderbrook Lane	Bowie If Under 1 Yea	r If Under 24 Hrs. 8. Date of	Prince Go	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las.	Yrs. Months Days	s Hours Min. (Month,		thplace (State or Foreign ountry)
b	Director		215-68-8416 52 Usual Residence of Decedent		Nov.	23, 1954 Per	ınsylvania
	yland now at		7	Town or Location			10d. Inside City Limits
	a-fst	ctor	Maryland Prince George's Bowi	.e			1 X]Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?
	ath w	ra La	2412 Kinderbrook Lane		715	U.S.A.	orinan Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Specify Yes or aban, Mexican, Puerto Rican, etc. o Specify:	Black, Whi	
215-0036	2 hou atura cal E	bed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occ	upation	16b. Kind of Business	/Industry
215	hin 7; an "n Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use reti	e during most of working red)	U. S. Dep	
21;	filed wit Hygiene other tha	P P	12	Contract Spe		of Agricu	lture
pu	be file ital Hy id oth	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Mid		
yla	should be not marked or ma	은	Kenneth Jay Littleford	40b Nacitica Address (Chro	Janice Gray		Zin Cadal
Maryland	12 sho hand 7 is ma trauma		, , , , , , , , , , , , , , , , , , , ,	•	et and Number or Rural Route No rook Lane, Bowi		20715
	1 and 2 Health em 27 i		20a Method of Disposition 20b. Plac	ce of Disposition (Name of	Date	20c. Location - City of	
nor	Pages nent of P int: If ite		1 ☐ Burial 2 To Cremation 3 ☐ Removal from State	netery, crematory or other p	ematory 4/9/200	7 Alexandria	Virginia
Baltimore,	그 들 다 글 .		21. Signature of Funeral Service Licensee		dress of Facility Robert E		
ä	permi Depar Impor any Ir		» Pl Knish		apolis Road, Bo		d 20715
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	SHANG	ying, such as cardiac or respirato	ry arrest,	Approximate Interval Between Onset and Death
	Examine	_	Sequentially list conditions, if any leading to immediate	DES UR			
	rted	nine	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1100 01/1			
Ć,	execu n and ial-tra	Exal	resulting in death) Last C Due to (or as a consequent	nce of):			
68760,	ficate be executed physician and the burial-transif	edical Examiner	d				
O. Box 68	ath certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome pf pregnant 1 □ □ ves in the past 12 months? 4 □ Pregnant at time of deal 9 □ Unknown	death 3 ☐ Ectopic pregna		23d. Date of do Month	elivery Day Year
ds, P.	w requires that the destable speen signed by the should be detached to	by	Part II. Other significant conditions contributing to death but not resulti	ing in the underlying cause		Did tobacco use contribute	to the cause of death? Probably 4 □Unknown
or Vital Records	law requasi been 2 should	Completed				Was an 24b. Were a	autopsy findings available
Re	sician: The law certificate has birector, page 2 s	duic			1 Y	performed? death?	completion of cause of
ta	an:] tifical tor, p	BeC	25. Was case referred to medical		26. Place of Death (Check o		3 22 110
>	> .∞ ¬	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 El	R/Outpatient 3 DOA	Other: 4 Nursing Home 5	Residence 6 □Other (Sp	ecify)
0		٦	27. Manner of Death 28a. Date of Injury (Month, Day Year) 2	28b. Time of lnjury 28c. In	njury at 28d. Desc vork?	ribe how injury occurred	
Si	Attending r death.	atic	2 Accident investigation		☐ Yes 2 ☐ No		
Division	or Att fter de Direct in by t	riffic	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At hom building, etc. (Specify)	ie, farm, street, factory, offic	ce 28f. Locati City o	on (Street and Number or F r Town, State)	Rural Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination				
	the hin 24 the F	/ledi	one) and manner stated. 29b. Signature and title of certifier	29c Lie	ense number	29d. Date signed (Mor	oth Day Year)
\	Neit Neit Neit		29b. Signature and title of certifier	6	6/7/5	8.9.0	>
,			30. Name and address of person who completed cause of death (Item 2	23a) (Type Print) An-	1 CRAMIDAIN	2000	(100 M N D
	8		CHARRY VENTURAR MAN MO	1	OREENBELT COLLEGE P	PARIX MA DA	UX U *3
		ate	31, Date filed (Month, Day, Year) 32, Resistrar's Signatu	ire	20011		
	Regist	rar	APR 1 2 2007	H heeks			

		•	For State of Maryis Registrar		tificate of L		-	giene Reg. No	71111	136	532
r	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	Day	y 007 Year	3. Time of	
46.	/Medic	al	Olive May McFarlane Brown 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat	April 3		County of Death	11:10	РМ
	Examin	er	2727 Woodlake Road		Bowie	Education of Boat	,,		rince Ge		
7	Funeral Director		5. Social Security Number 126-24-3283 6. Sex 1 □ M 2X F 7. Age (In y	vrs. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Da 08/16/]	th (y, Year) L912	9. Birth Cot WEST	place (State of Intry) JAMA INDIES	ICA
	land ow	1	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	cation					10d. Inside Cit	y Limits
	a-f sho	ctor	Maryland Prince George's	Bowie						1 X Yes	2 □ No
	or 28	Director	10e. Street and Number		10f. Zip Code			_	izen of What Co	intry?	
	eath w	eral	2727 Woodlake Road 11 Marital Status 12. Was Decedent Ever fi	n U.S. 13 \	20716	isnanic Origin? (S	Specify Yes or No	USA	14. Race - Amer	ican Indian,	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygene. If Health and Mental Hygene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever if Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hilf Yes, specify Cuba 1 ☐ Yes 2 ██No	Specify:	to Rican, etc.)		Black, White Specify: B1a	, etc.	
2-0	72 hor natur dical E	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	rking	16b. K	ind of Business/I	ndustry	
Maryland 21215-0036	within ene. than " he Me c	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired tered Nur			Me	dical		
d 2	filed Hygie other ent, th	Be Co	17. Father's Name (First, Middle, Last)	nogro			me (First, Middle,				
<u>lan</u>	2 should be fi and Mental H is marked ot aumatic ever	To B	Elkanah McFarlane			Blanch	Ferguson	n .			
lar)	2 sho and l is ma rauma	'	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street					ip Code)	
	1 and 2 Health tem 27		Shirley Brown/ Daughter 20a. Method of Disposition 20		Woodlake sition (Name of matory or other place		Date MD		LO ocation - City or	Town, State	
nor	ages ent of it: If its y or o		1 M Bunal 2 Cremation 3 C Removal from State		matory`or <i>otherpl</i> ac n Cemeter	1	1/2007		oklyn, N		
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr	i	21. Signature of Funeral Service Licensee		2. Name and Addres						e
8	permi Depar Impor any ir		photoming.		6000 Anna				D 20715		
d:			23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause of each line	leath. Do not ent	er the mode of dyir	ng, such as cardia	ic or respiratory a	rrest,		Approximate Interval Bet Onset and D	ween
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a con	sequence of:	7						
	Examiner		asolo	ation	n P	neur	ronia	i .			
	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):	/						
_	ecute and I-trans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con Due to (or	sequence of):							
68760,	tificate be executed g physician and as the burial-transit	al E									
	tificate ig phy as the	ledical	u.								
.O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pre 1 □ Live birth 2 □ Live birth 2 □	Fetal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	/			23d. Date of deli Month		Year
0_	that the		Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	tobacco	use contribute to	the cause of d	eath?
or Vital Records,	quires en sigr uld be	ed by					1 🗆	Yes 2	IDNo 3□Pr	obably 4 □l	Jnknown
ဝ၁	law re as bec 2 sho	Completed					24a. Was auto	DSV	24b. Were au	topsy findings	available ause of
E B	: The	Com	9.09				perfo 1□ Yes	ormed? 2 ☑ No	death?	2 □ No	
Vita	Physician: this certifical director,	Be	25. Was case referred to medical examiner? Hospital:	0 E E D / O	ot 3 DOA Oth	or.	eath (Check only				
ō	Physer this eral dir	1: To	27. Manner of Death 28a. Date of Injury	2 ER/Outpatier 28b. Time o	" OLI DOX	4 🗆 Nursing	Home 5 Resi 28d. Describe			cify)	
ion	ath. r: Afte	atior	1 [☑Natural 5 □ Pending (Month, Day Yea 2 □ Accident investigation	(r) Injury		K? Yes 2 □ No					
Division	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the accompletely filled in by the funeral director, page 2 should be detached.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - building, etc. (Sp.	At home, farm, str pecify)	reet, factory, office		28f. Location (City or To	Street a wn, Stat	nd Number or Ru e)	ral Route Num	ber,
	depit thours unera		29a. Certifier (Check only (Check only 2 ☐ Medical Examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner:								à)
	thin 2, the F	Medical	one) and manner stated. 29b. Signature and little of certified 2		29c. Licens		1		ate signed (Mont		
	F & F O		> Heller I & Marley	MD	000	2195	4	j	1-5	DM	
			30. Name and address of person who completed cause of death (21 13	/	7			
	3		Edward Mosley, MD 121		itral Avei	nue #2	12 Mitch	nelly	nie, MT	207	21
	Sta Regist		31. Date filed (Month, Day, Year) 32. Projector's S APR 1 2 2007	signature **	1						

			1 - For State Registrar	State of Marylar		irtment of H			ene 007	13633
	Physici /Medi		Decedent's Name (First, Middle, Last) JOHN DAVID BLAND	, JR				2. Date of Death Month APRIL 1	3, Day 2007 Yeer	3. Time of Death 12:10 P M
	Examir		4a. Fecility Name (If not institution, give str. 635 HIGH STREET			4b. City, Town, or CHESTER			4c. County of Death KENT	
	Funeral Director		5. Social Security Number 6. Sex 1213-82-5835 1 M h	7. Age (in yrs. 46	Yrs.	Months Days	Hours Min.		Year) 9. Birth Co.	place (State or Foreign intry) MD
	e Maryland Ba-f ehow	Director	10a. State 10b. County MD KENT	10c. Cit	y, Town or Lo	TERTOWN				10d. Inside City Limits 1 √ Yes 2 □ No
	N with th	ai Dire	10e. Street and Number 635 HIGH STREET			10f. Zip Code 21620		10	g. Citizen of What Cou USA	intry?
036	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f ehow its Mudical Examinar must be notified at	by Funerai	11. Marital Status 12 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	l ti	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: WHI	, etc.
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "natural", or items 23s or 28s-f show aumatic event, the Mudical Examiner must be notified as	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	16a. Deced (Give life. D	ent's Usual Occupa kind of work done of OO NOT use retired TER	ation during most of wo	rking 1	6b. Kind of Business/le	ndustry
yland ;	should be filed and Mental Hygies marked other immatic event, I	To Be C	17. Father's Name (First, Middle, Last) JOHN DAVID BLAND	, SR.			18. Mother's Nat JEAN PO	me (First, Middle, M ORTER	aiden Sumame)	
Mar	nd 2 sho alth and 27 is ma r trauma		19a. Informant's Name/Relationship (Type ROBIN BAKEOVEN BLA					STERTOWN,	City or Town, State, Zi, MD 21620	o Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic ex once.		20a. Method of Disposition 1 □ Burial 2 (X)Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)		emetery, crem	sition (Name of natory or other place E CREMAT(oRY 04/1		0c. Location - City or T	
Balt	permit. Departr Imports eny inj		21. Signature of Fugeral Service Licensee	Genbein) 22 F	Name and Addres ELLOWS F 30 SPEER	s of Facility IELFENBE ROAD, CI	IN AND NEW HESTERTOWN	NAM FUNERA N. MD 21620	AL HONE, PA
8/60,	Physicien and ph	i Examiner	23a. Part1. Enter the disease, or complied shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or	wence of):	Luve			st,	Approximate Interval Between Onset and Death
O. Box 6	the death certify the attending iched for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[\text{Yes} \ 2 \] No 9 \[\] Unknown	If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of do 9 Unknown	Ideath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
cords, P	es the gned be de	þ	Part II. Other significant conditions contri	buting to death but not rest	ulting in the un	derlying cause give	n in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
Š	The law ate has b page 2 s	Completed						24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of
DIVISION OF VITAL	Attending Physician: Tr death. ector: After this certificat by the funeral director, pa	Certification; To Be	2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work M 1 \(\)	^{Ir.} 4 ☐ Nursing H	28d. Describe how	ce 6 Other (Special injury occurred	
2	spitel or ours afte ours afte ours afte	al Certifi	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	·)		e date and place	City or Town,		
	To the Hos within 24 h To the Fur completely	Medical	one)	On the basis of examination and manner stated.	tion and/or inv	estigation, in my op	inion, death occu	rred at the time, dat	e and place, and due t	o the cause(s)
	5		> / huled	Ege -			9603	0)	1. Date signed (Month, 4 (13/0	7
	ന്വം Sta		30. Name and address of person who come M 1 CLY A COME 31. Date filed (Month, Day, Year)	Signa 32. Registry's Signa	& SKE	en PD	5725	CITE	PHI Bun	nul decto
1	Registr	ar	ADD 1 C	2007	A.	A. A.				

ORIGINAL

Registrar

State

31. Date filed (Month, Day, Year)

APR 13

CHOWDHURY, MD, 15216 DINO

32 egistrar's Signature

DRIVE; BURTONSVILLE, MD 20866

			State of Maryland / De	partment of Health and Mertificate of Death	•	ne2007 3635
	Physici /Medio		1. Decedent's Name (First, Middle, Last) MARJORIE ESTELE	GARK		Day Year 3. Time of Death
	Examir Funeral Director	ier	4a. Fecility Name (If not institution, give street and number) 5097 Lerch Rd 5. Social Security Number 6. Sex 1 M 20F 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death ShadySide If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "netural; or Items 23a or 28a-f show any Injury or other treumatic event, I'm Madical Examinal must be muffled at 200s.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or MD Anne Arundel ShadyS 10e. Street and Number 5097 Lerch Rd 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No It Yes, Stove Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th 17. Father's Name (First, Middle, Last) Aubry Southworth 19a. Informant's Name/Relationship (Type, Print) Kelly J. Proctor Daughter 20a. Method of Disposition 1 Daughter 20b. Place of Discombinery, Citype, Place of Discomb	ide 10f. Zip Code 20764 3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto It Yes, specify Cuban, Mexican, Puerto It Yes 2 No Specify: Dedent's Usual Occupation work in do work done during most of work in Do NoT use retired) Sekeeper 18. Mother's Name Delores Illing Address (Street and Number or Rura Tenth St. Chesic Position (Name of Fematory or other place) Peake 4/12	perity Yes or No-Rican, etc.) 16b. 16c. Profess, Middle, Maide Barnes 1 Route Number, City apeake B	i.4. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry Civate en Sumame) v or Town, State, Zip Code) each, MD 20732 Location - City or Town, State 1tsville, MD
ox 68760,	death certificate be executed was a strength of the contract	n/Medical Examiner	23a. Parf. Enter the disease, or complications that ceused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	22. Name and Address of Facility N. Wesley Chavis 1 0 684 SouthernMD Inter the mode of dying, such as cardiac o	r respiratory arrest,	nkirk, MD20754 Approximate Interval Between Onset and Death U 23d. Date of delivery
Vital Fecords, P.O. Box	e law requires that the d as leen signed by the le 2 hould be detached	Certification: To Be Completed by Physician/Me		B⊟Ectopic pregnancy □ Other (specify) underlying cause given in Part I.	23e. Did tobacco	Month Day Year Duse contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: Alter this certificate completely filled in by the funeral director, pag		25. Was case referred to medical examiner? 1	of 28c. Injury at Work? M 1 Yes 2 No street, factory, office	(Check only one) ne 5 Residence 28d. Describe how in 28f. Location (Street a City or Town, Sta	6 □Other (Specify) jury occurred and Number or Rural Route Number, te)
2	To the Hospi within 24 hour To the Funel	Medical	29a. Certifier (Check only one) 2 Medical Exeminer: In the best of my knowledge, dead one) 29b. Single Advite of the Chesapeake 30. Name and address of person who completed cause of death (Item 23a) (Type Michael J. LaPenta, M.D., 445 Def	er 29c. License number D 21438 e, Print)	ed at the time, date a	nd place, and due to the cause(s) Date signed (Month, Day, Year)
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 6 2007 APR 1 6 2007	U		

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

/Medic		MARIA GUADALUPE CAMPOS	4	112	107 3:27 PM
Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea 1) HIV GREST TO OF WARY LAND BALTIMORE	th	4c.	Couπty of Death
Funeral Director		5. Social Security Number NONE 1 M 2XX 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		ay, Year)	9. Birthplace (State or Foreign Country) MEXICO
D	tor	Usual Residence of Decedent	0/10/1	504	10d. Inside City Limits 1 □ Yes 2XX to
with the la or 28a I be notif	Director	10e. Street and Number 10f. Zip Code 25403			en of What Country?
death ms 23	Funeral		Specify Yes or No		4. Race - American Indian,
ours after rral", or Ite	þ	1 Never Married 2 X Married 1 Tyes 2 T No	MEXICAN		Black, White, etc. Specify: WHITE
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatla and Mental Hygiene. Important: I flem 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	orking	Ī	IN HOME
ould be filed Mental Hyg arked othe atic event,	To Be C		ARREGUI		•
und 2 sho alth and I 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) ANTONIO CAMPOS/SPOUSE 19b. Mailing Address (Street and Number of R			
Pages 1 ann of He rut; If item Iny or other		20a. Method of Disposition 1 XI Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of COUNTY of Place) 20b. Place of Disposition (Name of COUNTY of Place) 27,	L ^{Date} 2007		ration - City or Town, State HO, MICHOACAN, MEXICO
permit. Departn Importa any inju			ROWN FUNER	RAL HON WV 254	ME, P.O. BOX 821, 102
Physician /Medical Examiner physician and ph	cal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			Approximate Interval Between Onset and Death
i the death certificate be executed by the attending physician and ached for use as the burial-transit	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		2;	3d. Date of delivery Month Day Year
aw requires that th s been signed by t s should be detach	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t		se contribute to the cause of death?
sician: The law requires that certificate has been signed b rector, page 2 should be deta	Completed		24a. Was auto perfo 1∐ Yes		24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No
	Be	Hospital: Other:	eath (Check only o		
g Physer this er this eral di	٦: <u>۲</u>	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Home 5 ☐ Resi 28d. Describe		Other (Specify)
To the floopstal or Attending Physician: The lar within 24 hours after death. So the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	Matural 5	28f. Location (City or To		Number or Rural Route Number,
ne Hospiti In 24 hours he Funera pletely fille	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the control of the basis of examiners and the control of the basis of examination and/or investigation.	ce, and due to the curred at the time,	cause(s) a date and	and manner as stated. place, and due to the cause(s)
withi comi	×	29b. Signature and title of certifler 29c. License number AV4176435	5G1741	7	e signed (Month, Day, Year) 4/12/07
P		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	EENE	ST	-
Sta Registr		31. Date filed (Month, Day, Year) 32: Tegristrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April 10 2007 Year Robert Marshall Conlyn 10:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Calvert Memoriaal Hospital Prince Frederick 8. Date of Birth (Month, Day, Jan 22 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1√2 M 2□ F 216-38-5003 89 Washington DC 1918 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the IM dical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Calvert Prince Frederick Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20678 United States 4025 Adelina Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 ☑ No Specify: white þ Specify: 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Civil Engineer</u> Dept of Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William James Conlyn Helen Pearson Chapman ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Conlyn - son 7515 Breeze Bay Rd. Cumming GA 30041 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Metropolitan Funeral Service 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner due to klebsiella Preumoniae Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of Hnaemia 24a. Was an autopsy performed death? 1 ☐ Yes Stage 1□ Yes 2 □ No 2 W No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 8 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated.

29b. Signature and title of certifier

5851

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

church

eale

29c. License number

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29d. Date signed (Month, Day, Year)

SURANA

4-10-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Time of Death Day **Physician** Robert E. Cogan 09:10 PM April 2007 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 902 Shipmaster Court Annapolis Anne Arundel 6. Sex 1 XM 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 78 Director 157-20-9678 02/20/1929 New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland | Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 902 Shipmaster Court 21401 United States uneral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Baltimore, Maryland 21215-0036

Physician /Medical

Examiner

attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use:

Division or Vital Records, P.O. Box 68760

l by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 【X No Spec	cify:		Specify: Wh	nite
etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occupation kind of work done during	most of working	16b. F	Kind of Business/	Industry
To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	_	ance Broker		l Tn	surance	
Ç	17. Father's Name (First, Middle, Last)		THOUT		other's Name (Fi	irst, Middle, Maide		
10 B	William Maher Coga	n_		C1:	are Scan	nlon		
	19a. Informant's Name/Relationship (7			ng Address (Street and Nu				. ,
	Mary T. Cogan/Wife			Shipmaster C	ourt, An			
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crer	osition (Name of matory or other place)			ocation - City or	
	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen			ematory 2. Name and Address of Fa	4/12/0			Maryland
	Mr. Kali	20/	29	973 Solomons	Georg Island		as Funer water, M	al Home ID 21037
	23a. Fart . Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	Time	n. Do not ent	ter the mode of dying, such	as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	disease or condition resulting in death)	a. Due to (or as a consequ	uence of):	Pulmonar	7 , , 0,	10518		
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Exa	resulting in death) Last	Due to (or as a consequ	uence of):		-			
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mple						24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of
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To B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	Other		5 X Residence	6 ☐Other (Spe	cify)
tion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury at Work? M 1 □ Yes 2		I. Describe how inju	iry occurred	
Certification: To	3 Suicide 6 Could not be determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str	reet, factory, office	28f.	Location (Street a City or Town, Stat	nd Number or Ru e)	ural Route Number,
edical (ysician: To the best of my knowniner: On the basis of examina and manner stated.						
5	299. Signature and title of economics			29c. License numb		29d. Da	ate signed (Mont	h, Day, Year)
			00.)(7	D0058		4/	11107	
	30. Name and address of person who	completed cause of death (Item	23a) (Type,	Ave Suite 12	1 Anna	ptis my	714	01
te	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture					

State Registrar

APR 12 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death hambers niamin 0250 AM 007 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death County of Death stertown Dita 18 ens Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) Days Hours Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Informant's Name/Relationship (Type, Print) Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 □ Other (Specify) 21. Signature of Foneral Service Licenses 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ASPIRATION PNEUMONIA Due to (or as a consequence of) Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 🗌 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes

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Department o important: If eny Injury or page.

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ant of Heelth and Mental Hit: If Item 27 te marked out y or other traumatic even Pages 1 and 2 should be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Funeral Director: After this certific completely filled in by the funeral director,

or Attending Physician: The law requires that the death certificate be executed

death.

within 24 hours a To the Funeral E

Division of Vital Records, P.O. Box 68760.

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed Month, Dar, Year,

2

State Registrar

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician rnel 200 orl /Medical 4c. County of Death 4b. City Town, or Location of Death (If not institution, give street and number) **Examiner** Home MCKE If Under 24 Hrs. 7. Age (In yr last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min 1 M 2 F Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director COMERE 10e. Street an 10g. Citizen of What Country? ö 8 Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 21 No Specify: 3€Widowed 4 □ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) of Health and Mental Hygiene. College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 U I e ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pocomoke opper 2016 md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State -14-07 0 = Burial 2 Cremation ō 3 Removal from State Department of Important: If any injury or once. ames UNIC 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Benvie Smith Signature of Funeral Service License FOUTTH A ocomoke, md FUNEral Home 23a. Part1. Enter the disease, shock, or heart failure. L Approximate Interval Between Onset and Death nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final ATHEROSCLEROTIC Pnysician CARDIOVASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions by leading to in results cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, pe 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes director, page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No certificate has 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 No Other: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After I 1 Natural Injury 5 Pending after death. death. 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral (29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of pegities 29d. Date signed (Month, Day, Year) 29c. License number 2 4/11/2007 MD D0062172 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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	Physici /Medi		Richard Duffy						Marc Marc		Day Year 2007	9:45 a ^M
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57	Funeral Director		5. Social Security Number 030-24-9947	1 M 2 □ F	74	last birthday) Yrs.	Months Day		Min. (Mo	e of Birth nth, Day, Ye	ear) Cou	nplace (State or Foreign untry)
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	arylan show d at	- 1	10a. State 10b. County Maryland Montgo			y, Town or Lo						10d. Inside City Limits
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	with i	Funeral Director	11448 Schuykill	1 Dood			10f. Zip Code	•			Citizen of What Cou	•
	death ms 23 mus	era	11. Marital Status	12. Was Deceden	t Ever in U.	S. 13.	20852 Was Decedent o	f Hispanic Ori	igin? (Specify Ye n, Puerto Rican, e		ited State 14. Race - Amer	
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003	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates	:		1 □ Yes 21√2 N				Specify: WIII	
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b	e filed al Hyg other	BeC	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (First,	Middle, Mai	den Surname)	
ylar	Menta	ToE	Francis Duffy					Marga	aret Con	roy		
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type. Print) Mary Meleedy/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 88 Stillwater Drive, Nashua, NH 03062									ip Code)
6,7	1 and Health em 27 ther t		20a. Method of Disposition	ıster	20h P		111wate	r Drive	e, Nashu		03062 Location - City or T	Four State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (S		For				4/24/20	107		Rockville
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Box	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as:	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐Live birth 4 ☐ Pregnant	2 Fetal	ldeath 3□	Ectopic pregnar Other (specify)	псу			23d. Date of delive Month	/ery Day Year
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Э,	s that ned b e deta	by Pr	Part II. Other significant conditi	ons contributing to death	but not resu	ılting in the ur	nderlying cause o	given in Part I	. 230	e. Did tobac	co use contribute to	the cause of death?
rds	equire en sig ould by	ed b	Ventilator De	pendent Res	pirato	ory Fa	ilure			1 🗌 Yes	2∏ No 3☐ Pro	bably 4 □Unknown
ecc	2 53 29	Completed							248	a. Was an autopsy		opsy findings available ompletion of cause of
E B		Som							1	performed Yes 2	death?	2 □ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:				41	of Death Check			
	Phys this al dia	To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ∏ Inpat		ER/Outpatien 28b. Time of	C OLI DOA				e 6 Other (Speci	ify)
lon	Attending r death. ector: After oy the funer	tion	1 XNatural 5 ☐ Pendir 2 ☐ Accident investi	ng (Month, D	ay Year)	Injury	W	ork? ☐Yes 2☐		SCHOOLIGM I	iljury occurred	
	Atter	ifica	3 Suicide 6 Could 4 Homicide determ	sined Zoe. Flace of it	ijury - At ho etc. <i>(Specif</i> y	me, farm, str	eet, factory, offic	е	28f. Loc	ation (Stree	t and Number or Rui	ral Route Number,
Ö	ospital or Atten hours after death uneral Director: ly filled in by the	Certification:	- I tomode	building, e	stc. (Opecny	·/			City	or Town, S	tate)	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 ☒ Certifyir (Check only one) 2 ☐ Medical	ng Physician: To the bes Examiner: On the basis and manner s	of examinat	wledge, death tion and/or in	n occurred at the vestigation, in m	time, date ar y opinion, dea	nd place, and due ath occurred at th	to the caus e time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifie	7.071	` ~	0		nse number			Date signed (Month,	, Day, Year)
	1		• Usl	ush dole	es D	-0.	Н006				24/2007	
			30. Name and address of person						Tolia, I			
	Sta	te	31. Date filed (Month, Day, Year)		est G1 trar's Signa		d, Silv	<u>er Spr</u>	ing, MD	20910		
	Registr		APR 13	2007	see d	1 Apr	and I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Pay 2, 2 Year 7 Month APRIL **Physician** Michael Allen DELLINGER 3:10A /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore 8. Date of Birth Month, Day, Yeard 46 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1₩ 2□F Days 60 227-62-5147 Director Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Harford Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21087 United States 811 Petem Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 Tyes 2 No
If Yes, Give Year or Dates: 69-172 altimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify. 2 white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) University Prof. filed within 7 Hygiene. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Financial Planner Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Selma Rita Simon Robert Osborne Dellinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 Petem Road, Kingsville, MD 21087 19a. Informant's Name/Relationship (Type. Print) Nancy M. Dellinger, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 04/12/07 Alexandria, VA 21. Signature of curl al Solvice License Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIO-RESPIRATORY ARREST /Medical Due to (or as a consequence of) Examiner ISCHEMIC CARDIOMYOPATHY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit law requires that the death certificate be executed CORONARY ARTERY DISEASE Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the IF FEMALE signed by the attendin I be detached for use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 Tyes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No OBSTRUCTIVE SLEEP APNEA 24a. Was an 1☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 **X**No 1 inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 ☐ Pending investigation Injury To the Hospital or Attendivithin 24 hours after death.
To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

vithin 2 o the I

Medical

APR 1 3 2007 DHMH 17 Rev 1/2001

29b. Signature and title of certifier

TIMOTHY LOW

31. Date filed (Month, Day, Year)



use of death (Item 23a) (Type, Print)

and manner stated.

completed ca

29c. License number

D24034

signed [Month, Day, Year)

21204

29d. Date

			1 - For State Registrar	State of Maryla		artment of rtificate of		nd Mental	Hygiene Reg. No.	UU/	13643
	Physici	an	Decedent's Name (First, Middle, Last, BLANCHE LOTTI		C			Mont	of Death h Day .IL 17,		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of			County of Death	15:15 P ^M
			128 RACE TRACK R				ERSVILI			QUEEN AN	
	Funeral Director		220-12-0173	7. Age (In yrs	. /ast birthday) Yrs.	Months Days		Min. 8. Date (Moni	of Birth th, Day, Year) 0/1925	9. Birth Cou	place (State or Foreign ntry) MD
	nyland show	_	Usual Residence of Decedent 10a. State 10b. County MD QUEEN Al		CIIDIE:						10d. Inside City Limits
	he Ma	ecto	10e. Street and Number	NINE 5	SUDLE.	RSVILLE			10a Citi	izen of What Cou	1 ☐ Yes 2X No
	3a or	i Dir	100 RACE TRACK	ROAD		2166	8		USA		y
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Insupertent: It Item 27 Is marked other than "patural", or Iteme 23a or 28s-f show any injury or other traumatic event, Its Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu		n? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - Ameri Black, White Specify: BL	etc.
21215-0036	vithin 72 ho ne. han "natur Medical	Completed by	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+) 5+	(Give	dent's Usual Occu kind of work don DO NDT use retir	upation e during most o ed)	of working		ind of Business/Ir	•
0 0	filed w Hygie offher ti	CO	17. Father's Name (First, Middle, Last)	ЭŦ	1 E	ACHER	18. Mother	s Name (First, M		EDUCATIO Sumame)	N
Maryland	ould be Mental arked c	To Be	JOSEPH WILSON					CHE JOHN			
Mar	nd 2 sh alth and 27 le m r traum		19a. Informant's Name/Relationship (Ty SHEILA DAVIS/DAUGH			ng Address (Stree B RACE T					
ore,	ages 1 a nt of Hei : It Item : or othe		20a. Method of Disposition 1 🖔 Burial 2 □ Cremation 3 □ F	lemoval from State	cemetery, cre-	osition (Name of matory or other place ELS CEME'		Date		ocation - City or T	own, State
Baltimore,	ermit. Pa Separtme Inportant Iny Injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens					04/21/20 SEIN AND			L HOME, PA
	40244		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the dec						D 21620	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	TON	from	الملاد	?			Onset and Death
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68	ntificating phy	B	IF FEMALE:	•							
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Žį.	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:	7500		thor	of Death Check	- AUG	HTELLI	
Division of Vital	Attending Physician: r death. sctor: After this certification in the funeral director.	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Inj	4 U Nurs	28d. Des	Residence cribe how injur	6 ⊡Other (Speci y occurred	fy)
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	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	Medical C	29a. Certifier Control 2 Medical Exami	sician: To the best of my kiner: On the basis of examination and complet stated.	nowledge, deat nation and/or in	h occurred at the vestigation, in my	time, date and opinion, death	place, and due to occurred at the	time, date and	and manner as I place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	6/			nse number	. 2		te signed (Month	
1	2		Mulul	8			0060	0301		111810	7
_)	کار		30. Name and address of person who a	ompleted cause of death (lite	om 23a) (Type,	ler k	D 570	35 0	42518	Rock	7 nd 16/20
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 (32. Registre's Sign	nature	A.R.	9				

			For State Registrar	State of Marylan		artment of F rtificate of		/lental H	lygien Reg. N	ZUI	17	13644
		j.	Decedent's Name (First, Middle, Las.	t)				2. Date of	Death			3. Time of Death
	Physici		Mabel F.	Emmart				Month April		,	Year	2:00 a M
	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death			c. County of	f Death	2.00 a
			Bright View Assi	sted Living		Catons	sville		3	Baltim	ore	
	Funeral		Social Security Number 6. S	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of (Month,	Birth Day, Yea	r) (9. Birthpla	ace (State or Foreign
	Director		578-05-8979	□ M 2 KDN 92	Yrs.			Oct.				ínia
	P ,		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	eation					10	d. Inside City Limits
	anyla shov d at	_	10a. State 10b. County	100. 011	y, rown or Lo	cation						1 ☐ Yes 2½ No
:	ne M 8a-f otifie	Director		George's	Ri	verdale			140 0	NAT 6 1841-	-101	
	be n		10e. Street and Number			10f. Zip Code			10g. C	Citizen of Wh	nat Count	ry r
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral	6610 Greenland		0 40		20737		NI.	14. Race -	JSA	n Indian
	er de Itema	un	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.5. 13.	lf Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	No-		White, e	
30	s aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 █ X No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:			Specify:	Whi+	Δ.
3	hour al Ey	DE L	15. Decedent's Ed		16a Dece	dent's Usual Occu	nation		16h	Kind of Busi		
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	filed Hygi Sther ent, tl		12. Tather's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Mide	dle, Maide	en Surname,)	
<u> </u>	d be ental ced c	To Be	Charles Furr				Aman	da Cha	ppel			
Maryland	I 2 should be filed vand Mental Hygie vand Mental Hygie van warked other traumatic event, the	F	19a. Informant's Name/Relationship (7	vpe. Print)	19b. Mailii	ng Address (Street	t and Number or Ru	ral Route Nui	mber, City	or Town, S.	tate, Zip	Code)
2 2	s 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hygiene. I then 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 20a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Phyllis McVearry/	Daughter	6	610 Green	nland Str	eet R	iver	ale	MD 2	0737
บั	t and 2 Health tem 27 i		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of)	Date		Location - C		
2	Pages nent of h unt: If lite ury or of		1 ₺ Burial 2 ☐ Cremation 3 ☐	Removal from State	-	matorý or other pla 11 Cemete	rv Apri.					
baltimore,	permit. Pages 1 ar Department of Hee Important: If Item any injury or othe once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	/			200			land,		yland
מ	permit. I Departm Importar any inju			7C.00			ess of Eacility Collin					g, MD 2090
	cate be executed was hysician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causes (Disease of Infany that initiated events resulting in death) Last	b								
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	or Attending after death. Director: After in by the fune	icat	3 Suicide 6 Could not be		ome farm sti			28f Locatio	n /Street	and Number	r or Bural	Route Number,
\leq	i diffe	Ţ.	4 ☐ Homicide determined	building, etc. (Speci	fy)	oct, tablery, office			Town, Sta		or riaras	rioute Namber,
-	pital ours (eral filled		29a. Certifier 1X Certifying Ph	ysician: To the best of my kno	owledge, deat	h occurred at the t	time, date and place	, and due to t	he cause	(s) and man	ner as st	ated.
	To the Hos within 24 ho To the Fun completely	Medical	one)	niner: On the basis of examination and manner stated.	and and/or if			med at the tir	ne, uate a	uru piace, ar		uie Gause(s)
1	To the To the Complete	M	29b. Signature and title of certifier	shal Bu	and,	29c. Licen D262	se number 287		1	Date signed or 1		*
	Ψ		30. Name and address of person who of Michael Berard,				e, #107, G	Colleg	e Par	ck, MD	207	40
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 3 20	32 Registrar's Sign	ature	ante						

-	2000		1 - State Registrar		artment of Health and M rtificate of Death	Rag. N	<u> 2007 13543</u>					
3 W	Physici	an	Decedent's Name (First, Middle, Last)			Date of Death Month	3. Time of Death					
	/Medic	al	Cassie Louise E 4a. Facility Name (If not institution, give street and r	arnest	4b. City, Town, or Location of Death	April 12,	2007 8:55P M					
-	Examin	er	3811 Bayview Drive	umber)	Chesapeake Beach	•	Calvert					
	Funeral	(48)	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign					
36	Director		220 - 48 - 5386 ^{1□ M 2⊠F}	89 Yrs.	Months Days Hours Min.	Jan. 16,	1918 Hanover, VA					
	pui 🛊		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits					
	Maryla I sho	ō	,				1 ☐Yes 2√∑No					
	the A	rect	Maryland Calvert 10e. Street and Number	Cnesapea	1 ke Beach 10f. Zip Code	10g. (Citizen of What Country?					
	3a or	Funeral Director	3811 Bayview Drive		20732		USA					
	deat	ner	11. Marital Status 12. Was De	cedent Ever in U.S. 13. Forces?	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.					
98	or Ite	Y.F.	1 Never Married 2 Married 1 Yes	2 🔯 No Give	1 ☐ Yes 2 ☒ No Specify:		Specify: White					
21215-0036	tural',	ed by	3 ☑ Widowed 4 ☐ Divorced Year or 15. Decedent's Education		edent's Usual Occupation	16h	Kind of Business/Industry					
5	in 72 n "na	Completed	(Specify only highest grade completed	d) (Give	e kind of work done during most of work DO NOT use retired)	ing 166.	Kind of Business/Industry					
212	d with giene. rr the	Шо	Elementary/Secondary (0-12) College	(1-4or 5+)	omemaker		Own Home					
pu	should be filed within 72 hours after death with the Maryland not Mental Hyglene. I marked other then "netural", or items 23e or 28e-f ehow umatic event, I to Medical Exerti or must be inclined at	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Maid	en Surname)					
Maryland	Ment Ment arked aric e	P P	Frank E. Parsley			Leber						
Jar	2 should and less many les		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number or Rura							
e,	1 and 2 Health ar em 27 Is		William E. Earnest - So 20a. Method of Disposition	1 381.	Bayview Drive, C		Beach, MD 20732 Location - City or Town, State					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other then "natural", or Items 23a or 28a-f ehow army njury or other treumatic event, the Medical Exact instructs to purified at another.		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from	n State cemetery, cre	In Cemetery 4/16							
₫	nit. P		4 Donation 5 Other (Specify) 21. Signalum Fineral Service Licensee		2. Name and Address of Facility		entwood, Maryland B9 Baltimore Ave.					
Ba	permit. Departr Importe any nje		Value frant		•		attsville, MD 20781					
Ī.			23a. Part1. Enter the disease, or of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
	Physician		Immediate Course (Final	al failure			Onset and Death 1 month					
	/Medical		resulting in death)	o (or as a consequence of):			1 monen					
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	be fis	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Congestive heart failure Due to (or as a consequence of):									
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8760,	ate be executed hysician and the burial-transit	calE										
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Box	Attending Physician: The law requires that the death certificate be executed rideath. scior: After this certificate has been signed by the attending physician and by the tuneral director, page 2 should be detached for use as the burial-transit.	Physician/Med	23b. Was decedent pregnant	outcome of pregnancy birth 2 Tetal death 3	⊒Ectopic pregnancy		23d. Date of delivery					
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₹	s cart	To Be	examiner?	Inpatient 2 ER/Outpatie	Othor	n (Check only one)	6 ☐Other (Specify)					
Division of Vital	g Physier this	on: T	27. Manner of Death 28a. Dal	e of Injury 28b. Time onth, Day Year) Injury		28d. Describe how in						
<u> </u>	ath. or: After	atlo	2 Accident investigation	mining	M 1 Yes 2 No							
<u>≅</u>		Certificati	3 Suicide 6 Could not be determined but	ce of In jury - At home, farm, si Iding, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)					
Ω	urs af urel D											
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exeminer: On the	To dest of my knowledge, dea basis of examination and/or in anner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)					
	To the H within 24 To the Fi complete	Mec	29b. Signature and title of certifier		29c. License number		Date signed (Mgnth, Day, Year)					
)	- s + ō			ys/_	D56/6/	/	04/14/2007					
	(6)		30. Name and address of person who completed ca	use of death (Item 23a) (Type	D56/6/ PD O BOX 24	1/ ~	0 000					
-(6)		HNSON J. JOSE	PH, MD,	PUSOX 24	24, 10)	0 20678.					
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 6 2007 32.	Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 8:45 PM FINGERHU 200 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ROCKVILLE HOME MONTGOMERY BREW WASHINGSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6 /30/1915 9. Birthplace (State or Foreign Country) Russia 5. Social Security Number 578-01-4504 7. Age (In yrs. last birthday) 91 Yrs. Days Hours Min. 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 No Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6121 Montrose Road 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned White 1 Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Minnie "Unknown" Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Earle Fingerhut - Son 9 Colebrook Court Potomac MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Gardens 4/12/07 Falls Church, VA Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Server Lices Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DISEASE ON Due to (or as a consequence of): ++ Sequentian, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ⊠ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ERLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Ba. Date 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 2 Accident

/Medical Examiner the attending physician and the for use as the burial-transit Box 68760 signed by the atte Ö ۵. Records, cate has been signated the page 2 should the certificate has Division of Vital

Examine Physician/Medical þ Completed funeral director. Be Certification: To this al or Attending F s after death. after death.
Director: Aft filled in by

Physician

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Examiner

MD

Director

Completed by Funeral

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To

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Director

ed other than "netural", or items 23s or 28s-f show event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or item sny injury or other traumatic event, the Mudical Examinat once.

Physician

21215-0036

Maryland

Baltimore,

	OSTEOP
1	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♠ No
l	27. Manner of Death

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

6 🗀

	28
Pending investigation	
Could not be determined	28

of Injury hth, Day Year)	28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b.	Signature	and	title	of	certifie

29c. License number

MD

29d. Date signed (Month, Day, Year) 9,2007

Ane	Konan,	MD	15/	284	
ame and address of perso	n who completed cause of death	(Item 23a) (Type, Print)	6105	MONTE	205

State Registrar

Medical

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

To the Hospital c within 24 hours af To the Funerel D

			1 - For State Registrar	State of Marylar	· ·	nt of Health and te of Death		giene Reg. No.	007	13647	
	Physici /Medic		1. Decedent's Name (First, Middle, Las	Rebecca	Farm	ER	2 Date of De Amonth April	Day C	2007	3. Time of Death 3: ZZ A M	
	Examir Funeral	er	4a. Facility Name (If not institution, give 1407 Potom4c) 5. Social Security Number 6. S	Heights D	RIVE FT	r, Town, or Location of Dea	TCN MI) PR	9. Birth	Delace (State or Foreign	
ų.	Director		220 - 38 - 1180 15 Usual Residence of Decedent 10a. State 10b. County	□M 2XF 67	Yrs. Months	Days Hours Min	2-11-	194	0 19	ARYLAND 10d. Inside City Limits	
	the Maryia 28a-f shor	ector	Maryland Prince	GEORGE'S FOI	et WASH	INGTON ip Code		10g Citiz	en of What Cou	Yes 2 No	
	leath with	Funeral Directo	1407 Potom.	12. Was Deceden Ever in U	DRIVE 2	0744-	Specify Yes or No	Unit	ted S	itates can Indian,	
5-0036	ours after o	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, sp	ecify Cuban, Mexican, Pue	rto Rican, etc.)		Black, White,	ack	
21215-0	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other then "natural", or Iteme 23a or 28a-f ehow umatic event, the Madical Exeminer must be mailfied at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of w life. DO NOT	rork done during most of wo	orking	16b. Kin	d of Business/Ir	ndustry	
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) FRANCIS XAVIE	young, S	R.		me First, Middle,		Bake	'n	
	od 2 Ith a 27 is		19a. Informant's Name/Relationship (T Seleva Wad	e (Daughter)	1407	OTOMAC TEIG	nts DRIVE	F	WASHING	FON M.D	
altimore,	0 0 = 5		20a. Method of Disposition Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	Removal from State	Place of Disposition (N. cemetery, gramatory or RY IONU VETER)	other place)	f/11/07	chel	ation · City or · tenham	MA)	
Ball	permit. Pag Department Important: any injury o		21. Signature of Europial Service Goens	Simmens_	PopeFul	and Address of Facility DEVAL Homes, Pi	A. Fores	tvill.	arl Bor E, MD	o Pike 20147	
	Physician		23a. Part1. Enter the disease, or composhock, or help failure. List only of immediate Cause (Final disease or condition	M	th. Do not enter the mo	1	ac or respiratory and	rrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a consect							
	ecuted and -transit	Examiner									
8760,	icate be executed physicien and s the burial-transit	icai									
O. Box 6	death certif e attending id for use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3 ☐ Ectopic			2:	3d. Date of deliv	ery Day Year	
ds, P.O	ires that the signed by dipe detact	þ	Part II. Other significant conditions co	entributing to death but not res	ulting in the underlying	cause given in Part I.				the cause of death?	
Records,	or Attending Physician: The law requires that the titler death. Director: After this certificate has been signed by the tine tuneral director, page 2 should be detached in by the tuneral director, page 2.	Completed					24a. Was	an osy rmed?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of	
<u>Ital</u>	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?				eath Check only o	nej			
ō	Physi r this o	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3	OOA Other: 4 Nursing 28c. Injury at Work?	Home 5 Resident			fy)	
ion	Attending For death, actor: After by the funer	ation	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury M	Work? 1 ☐ Yes 2 ☐ No					
Division of Vital	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Special	(5)		City or To	wn, State)		al Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the curred at the time,	cause(s) a date and	and manner as a place, and due t	stated. to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	Nal	3 2	9c. License number			signed (Month,		
	J.C			NOYA, MD	200 5	MO 03627	2	4	10/20	207	
	(10)		30. Name and address of person who of 2150 PENNSYLVAI			ze Wm	MINATON	DC	2003	3	
	Sta Registr		APR 13 2007	32. Registrar's Sign	ature						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 30, Geraldine March 2007 Ford 6:42 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11511 Lovejoy Street Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 78 Yrs. Months Days Hours Min. Oct. 4, 1 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 25F 1928 Temple, Texas 577-64-8693 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Montgomery Silver Spring 1 Tyles 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 11511 Lovejoy Street U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglene important: If item 27 is marked other than "natural", or lies any injury or other traumatic event, the Medical Evanthes ADRE. 1 ☐ Yes 2X No II Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaners Owner, Jerry & Son 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Grant Reed Sr. Helena Malone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jones Daughter 11511 Lovejoy St.Silver Spring, MD. 20902 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Cem. Apr.7,07 Rockville, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Şervice Hitense 22. Name and Address of Facility Hunt Funeral Home Tramus 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Uterine Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner certificate be executed ed by the attending physicien and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 🙀 No Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' P Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 ☐ Yes 2 € No 1 ☐ Inpatient 2 ☐ ER/Outpatient this 3 DOA 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending P within 24 hours after death.
To the Funerel Director: After 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛮 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number vanone D0064615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wroblewski Genevieve ind 1355 PICCurd 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 13 2007 Registrar

Kimberly Kathleen J		ate of Maryla	nd / Depai	rtment of	f Health and				200	7 13649
	Registrar 1. Decedent's Name (First, Middle	e,Last)	Cen	tificate of	Death		2. Date o			3. Time of Death
Medical Examiner	Kimberly Katl				4b. City, Town, or I	ocation of I		10, 2007	Year County of Deat	1439 hrs
-	Prince Georges Hospit		nber)		Cheverly	LOOGHOIT OF L	Bouit		nce Georg	
Funeral Director	5. Social Security Number 579–94–1751	6. Sex	7. Age (In yrs. Ia:		If Under 1 Year Months Days		Min	of Birth(MM/DI	Forei	rthplace (State or gn Washington.
	Usual Residence of Decedent	M ZAP		Yrs		<u>L</u>	017	11/19/		ъ.С.
ow any	10a. State 10b. County	Arundel		Town or Locat						10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f sho tiffied at once.	Maryland Anne A	Arunder		Severn	10f. Zip Code			10g. Citize	n of What Cou	
the Ma Sa or 28 otified	108 Edelton Ave	enue			21144	4			USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 X Ma				is Decedent of His es, specify Cuban,				1. Race - Ame White, etc.	rican Indian, Black,
fter de: I'', or i		1 Yes orced If Yes, Give Year or Dates:	2 X No	1	Yes 2X No	specify:		Sį	pecify: BL	ACK-
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5-0036 cled within 72 hour lygiene. other than "natu the Medical Exar Completed	Elementary/Secondary (0-12)	College (1-	-4 or 5+)	Recr	uiter			T	anspor	tation
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2121 tould be fi d Mental I is marked tic event,	Raymond 19a. Informant's Name/Relationsh			19b. Mailing	Address (Street		Peggy C		or Town, State	e, Zip Code)
MD 212 shouth and 127 is unmatic	Michael A. Fu			108	Edelton A	Avenue	e, Sever	n, Mary	yland 2	21144
ore, of Heal of Heal If iten	20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal fro	om State Cr	rematory or ot		- 1	Date		cation - City o	
ltime it. Pagi rtinent ortant: y or ot	4 Donation 5 Other Sp 21. Signal of Funeral Service	ecify:	Re		tion Cem		4/14/07			Maryland eral Home
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ox 6 zath cer attendi for use	1 Yes 2 No 9 V Unk		ant at time of dea	-46	ther (Specify)			_		
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ision of Vital Records Attending Physician: The law requiredath rector: After this certificate has been by the funeral director, page 2 should ication: To Be Complete	examiner? 1 Ves 2 No	11	npatient 2	ER/Outpatient		045	Nursing Home			er:
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Div ours aft ours aft filled in	4 Homicide deter	mined (Specify)	Local Stree				3393 Do	own, State) innell Drive, F		
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: / completely filled in by the fi Medical Certification	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exal	nysician: To the bes miner:On the basis o	of examination ar	ge, death occu nd/or investiga	rred at the time, da ition, in my opinion	ate and place , death occu	e, and due to th urred at the time	e cause(s) and , date and place	manner as sta e, and due to t	ited. the cause(s)
To result with To com	29b. Signature and title of certifie	and manner s	tated		29c. Licens	e number		29d. Da	ate signed (M	onth, Day, Year)
	Vn	N1. //			O.C.I	M.E.		April	11, 2007	
6	30. Name and address of person Jack Titus MD. Dep	who completed caus			nn Street, Balt	timore, M	ID 21201			
State	31. Date filed (Month, Day, Year)	32.	gistrar's Signatu							
Registrar	APR 12	2007	eve !	7. 1						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ror State Registrar AMEND#23aI+IIperMD4/20/07, BMN, McCo Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** APRIL 11, 2007 5:12 P. LILLIAN GOLDMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fox Chase Nursing Home Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕅 F New York January 10, 1922 Director 082-14-6747 85 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ä 1 X Yes 2 No notified Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code with ō ber United States 1230 Woodside Parkway 20910 23a death v the Medical Examiner must Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11 Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify þ 3 ☑ Widowed 4 ☐ Divorced white "natural" Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Nathan Peckins Jenny 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a tem 27 is Department of Health Important: If item 27 any injury or other tr 1230 Woodside Pkwy., Silver Spring, MD Paul Goldman, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 ARemoval from State 4 □ Dopation | 5 □ Other (Specify) United Hebrew Cemetery 4/13/2007 Staten Island, New York 21. Sign ture of Funeral Survice Lic 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, MD 20904 Jan 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Renal Cancer - Metastatic Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** vear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, and y leading to inmode cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be executed burial-transi and Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Linknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure to Thrive Dementia Advanced 1 🗌 Yes 2 No 3 ☐ Probably 4 ☑Unknown Completed Anemia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 ☐ Yes funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760 Division or Vital Records,

Baltimore, Maryland 21215-0036

State Registrar

filled in by

Medical

24 hours a

To the I within 2

9

4 Homicide

29b. Signature and title of certifier

29a. Certifier

Ravi Passi, M.D., 8609 Second Avenue, #404B Silver Spring, Maryland 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

APR 13

and manner stated.

Registrar's Signature

##Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D28656

29d. Date signed (Month, Day, Year)

April 12, 2007

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		Ragistrar		Cei	rtificate of l	Deam		Reg. No.		
Physic	cian	Decedent's Name (First, Middle, La	1 1 1	7 00	100		2. Date of De	Day	Year O.	of Death
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Exam	iner	4a. Facility Name (if not delitation, giv	1/100	-01	1	10110	1			V.0
Former		5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir (Month, Da	7-0-	9. Birthplace (State	
Funera Directo			I	Yrs.	Months Days	Hours Min.	(Month, Da 4/8/1	ıy, Year) 1952	9. Birthplace (State Country) Maryland	
ס		Usual Residence of Decedent					1707	752		
inylan show	_	10a. State 10b. County		ity, Town or Lo	ocation				10d. Inside	
Ba-f s	cto	PA	Y	ork						es 2 No
or 2	Director	10e. Street and Number	a		10f. Zip Code			10g. Citizen of		
YIGITION CITY IN 2000 Ould be filed within 72 hours after death with the Maryland Mental Hygiene. Arkad other than "natural", or items 23e or 28e-f show afte avent, Ite Marites Evantrar must be retilized at	ral	513 Wynwood R		10	17402			U.S.A		
ter de	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 XNo	J.S. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Bla	ce - American Indian, ck, White, etc.	
nours aff	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specif	black	
2 hou	ed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation		16b. Kind of B	usiness/Industry	
hin 7:	Completed	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wo d)	rking			
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m - 0 -	Be (17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle	, Maiden Sumar	ne)	
aryicar should be ind Menta i markad umatic av	10	Alfred Gordo	n			Ruth	Haskin	s		
and and is my		19a. Informant's Name/Relationship (1.	ng Address (Street					
5 PEV =			/ son		Wynwood					
DallIIIOCE, permit. Pages 1 and Department of Heall Important: If item 2 any injury or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □			sition (Name of matory or other plac		Date	20c. Location	- City or Town, State	
Dallimor Dermit. Pages Department of I mportant: If its any injury or o		`4 □Donation 5 □ Other (Special			n Cemet		-		awn, Md.	
Description of the control of the co		21. Signature of Funeral Service Lice	nsee		2. Name and Addres		Jnivers			eze trean are
00580		1117711	m						gton,DC	
		23a. Part1. Enter the defease, or com- shock, or heart failure. List only	one cause on each line.	th. Do not ent	er the mode of dyin	ig, such as cardia	or respiratory a	rrest,	Approxim Interval B Onset an	Between
Physician	-	Immediate Cause (Final disease or condition resulting in death)	a Non-Sm	alle	ell Lui	ng Ca	nce	V	MON	ths
/Medica Examine	_	resulting in dealin)	Due to (or as a consec	quence of):		٦			1	
	и.	Sequentially list conditions,	b. Due to (or as a consec	Tuence of						
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener onderlying Cause (Disease or injury	500 (0) 00 00 00 00	quonos ory.						
axecu a and al-tra	xar	that initiated events resulting in death) Last	Due to (or as a consec	quence of):						
e be ey sician buria	calE		4							
ificate g phy as the			u							
ox orth	Physician/Med	iF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		7			23d. Da	ite of delivery	
death death d for	icia	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		Ectopic pregnancy Other (specify)		<u> </u>	Mo	onth Day	Year
by the	hys	9 ☐ Unknown	9□ Unknown							
The Corrus, F.O. box 00/00, The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use con	tribute to the cause o	f death?
w requires to been signer should be							1 🗆	Yes 2□No	3 ☐ Probably 4 ∫	Unknown
aw re	ompleted						24a. Was	an 24b.	Were autopsy finding prior to completion of	s available
VICAL THE SICIENT THE SAW CONTINUENTE HAS E	E						perfo	rmed?	death?	cause or
VICION: Icion: Sertifica	BeC	25. Was case referred to medical				26. Place of De	ath (Check only o	-	Sub	acute
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endii eath. or: A	Satle	2 Accident investigatio			M 1 🗆	Yes 2□No				
or Att	Certification;	3 Suicide 6 Could not be determined		ome, farm, str	eet, factory, office		28f. Location (City or To		ber or Rural Route Nu	ımber,
ital c										
Hosp 4 hou Funa tely fi	edical	(Check only 2 Medical Exal	nysician: To the best of my kno niner: On the basis of examina	owledge, deatl ation and/or in	n occurred at the time vestigation, in my of	ne, date and place pinion, death occu	e, and due to the irred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause	3(S)
To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Med	29b. Signature and title of certifier	and manner stated.		29c. License				ed (Month, Day, Year)	
H 3		La de la de la de la de la dela de la dela de	Calula: 11	1-1.0	+ 1,20	912		1-1	10 200	
17)		mustine !	again HOSP	179115	Brien	1100		ubi,	110 20	
SIC		30. Name and address of person who	completed cause of death (Iter	11 23a) (Type,	(a	+ Rnn	d Rain	dollat	DUM MA.	allan.
- C	tate	31 Date filed (Month, Day, Year)	32. Registrar's Signa	ature	LUMY	1 100	4141	MULIST	UNTI, 14 191	7 10010
, J	de le	AUD 4 4 9BA7 A	N4 1"	1.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6:00A M Lawrence Wendell Gilbert, Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Lanham Doctors Community Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 5, 1931 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) Days Min Maryland 75 577-40-3208 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 □Yes 2 No Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20720 13316 Mockingbird Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1952–54 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mail sorting equip. Field Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lawrence W. Gilbert Grace B. Penix

12013 Twin Cedar Lane

22. Name and Address of Facility

6512 NW Crain Hwy.

Veterans Cemetery 04/16/2007

20b. Place of Disposition (Name of cemetery, crematory or other place)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Bowie, MD.

Beall Funeral Home

Bowie, MD.

20715

20c. Location - City or Town, State

Crownsville, MD.

SUITE 272 BOWIE MUDOTIS

20715

Approximate Interval Between Onset and Death

/Medical

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show notified at

ral", or items 23a or Examiner must be r

other traumatic event, the Medical

ال Should be filed within 72 hours after ا and Mental Hygiene. I**s marked other than "nature!!**

of Health a

Pages 1

timore, Maryland 21215-0036

Director

Funeral

Completed by

Be

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19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen

20a. Method of Disposition

Immediate Cause (Final

Lawrence W. Gilbert, Jr. / Son

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician Examiner

> burial-trar the attending p as signed by t d be detach certificate

requires that the death certificate be executed

Hospital or Attending Physician:

IVA

Division or Vital Records, P.O. Box 68760,

Physician/Medical Examiner Completed by Be Medical Certification: To within 24 hours after community to the Funeral Director: Aft

disease or condition	a. neumonia				weeks
resulting in death) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Chonic obstruction of the consequence of the consequ	ve Pulmona	y Diste	ust.	Jeans
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregr 4 ☐ Pregnant at time of death 5 ☐ Other (special of the context)			23d. Date of de Month	livery Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underlying caus	se given in Part I.			o the cause of death? robably 4 □Unknown
			24a. Was an autopsy performed? 1 Yes 2 No	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical		26. Place of Death (0	Check only one)		
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 → topatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home	5 ☐ Residence	6 □Other (Spe	ecify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	n M	Injury at Work? 1 Yes 2 No	d. Describe how inju	ry occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)	ffice 281	f. Location (Street al City or Town, State	nd Number or R e)	ural Route Number,
	ysician: To the best of my knowledge, death occurred at t niner: On the basis of examination and/or investigation, in and manner stated.				
29b. Signature and title of certifier	Laung MD I	120108	29d. Da	te signed (Mon	th, Day, Year)

DHMH 17 Rev 1/2001

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Registrar

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hagerstown Crematory 4/17/07 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Immediate Cause (Final disease or condition resulting in death)

Stabe IV onal COUIN Due to or as a consequence of): rspinator Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sephic

Due to (or as a consequence of) Acute aneni

IF FEMALE:

If yes, outcome pf pregnancy 23b. Was decedent pregnant

1□Live birth 2□Fetal death 4□Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

23d. Date of delivery Month

CENC

Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown

2007

Washington

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 No

Maryland

14. Race - American Indian

Hagerstown, Maryland

White

Black, White, etc.

4c. County of Death

1954

USA

Specify:

16b. Kind of Business/Industry

24a. Was an autopsy performed 1∏ Yes 2 7 Na

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 Tes 2 1 Ho

26. Place of Death (Check only one) 11 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

MAIN

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 5 □ Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28c. Injury at Work? 1 □ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ⊟Natural

2 ☐ Accident

3 ☐ Suicide

1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

E. Anheram St 251 Haperstown HTIQUE MBAOUA , MD 32, Registrar's Signature 31. Date filed (Month, Day, Year)



Physician Examiner P.O. Box 68760.

/Medical

Examiner

Physician/Medical

Completed by

Be

P

Certification:

Medical

for use as

attending physician and for use as the burial-tran Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

State Registrar

		,	1 - For State Registrar	State of Maryla	-		of Health of Death		Re	19. No UU /	13654
	IIII E	7,	1. Decedent's Name (First, Middle, Last)					2.	Date of Deat	h Day Year	3. Time of Death
	Physici	- 6	Ellen Virginia	Guyer				A	PRIL	10 2007	10:45 PM
100	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Tox	wn, or Location	of Death		4c. County of Deatl	1
		<u> </u>	304 Cedar Grove Roa	ıd		Edgew	ater			Anne Arun	del .
46.	Funeral Director		5. Social Security Number 6. Sex		s. last birthday) 84 Yrs.	If Under 1 Y Months D	rear If Under Pays Hours	24 Hrs. 8. Min. 00	Date of Birth (Month, Day, Ctober	Year) 9. Birtl Co 1,1922 Vir	nplace (State or Foreign untry) 'ginia
100	P.		Usual Residence of Decedent								10d. Inside City Limits
	how	_	10a. State 10b. County	100. 0	City, Town or La	cation					1 ☐ Yes 2 🛣 No
	Ba-f.	cto	Maryland Anne Arur	ndel Ed	lgewate						
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic avent, I're Medical Examinate motiliad at a fingury or other traumatic avent, I're Medical Examinate motiliad at a.	Funeral Director	10e. Street and Number 304 Cedar Grove Ro	oad		10f. Zip Co	L037		10	0g. Citizen of What Co USA	untry?
	deat	ner	11. Marital Status	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deceden	t of Hispanic Or Cuban, Mexica	igin? (Specif	y Yes or No-	14. Race - Ame Black, White	
9	or Ite	F	1 Never Married 2 Married	1 ☐ Yes 2X☐XNo If Yes, Give			No Specify		,	Specify: Whi	
21215-0036	ral',	by	3XOWidowed 4 □ Divorced	Year or Dates:		103 24	2110 Opcomy	•	1.0	Speeny. WILL	. LC
20	72 h natu	tec	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	dent's Usual C	Occupation done during mos retired)	st of working	T	16b. Kind of Business/	•
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	ad wi	Completed by	6		Dell	ппртој					
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<u>a</u>	Ald by Menti	၉	Walter Wallace Tag	pscott			Bert	tha Ma	ae Tag	pscott	
Maryland	12 should be filed within h and Mental Hygiene. 7 le marked other than "traumatic svent, the Men		19a. Informant's Name/Relationship (Type							City or Town, State, 2	
	alth alth		Dale V. Guyer - So					d., Ed:	gewateı	r, MD 21037	
5	iter oth		20a. Method of Disposition	20b.	Place of Dispo	sition (Name natory or othe	of or place)	Date	9	20c. Location - City or	Town, State
Ę	Page ent c nt: If		1 XBurial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)				onal Cer	m. 4-2	6-07	Arlington,	VA
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It any injury or other tra 2002.		21. Signature of Funeral Sergice License	4	(20	Name and	ddress of Facil	Euno	ral Hor	ne, P.A.	
ä	permi Depa Impo any ii		> Jene 1. Keel	4	2	973 So.	Lomons .	Island	Rd. E	dgewater, N	ID 21037
	07-17-3		23a. Part1 Prior the disease, or compli	cations that caused the de							Approximate Interval Between
			shock, or heart failure. List only on Immediate Cause (Final				F 4				Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a cons		AMI	TAIL	URE			
	Examiner			Due to (or as a cons	oquerico (i).						
		<u>-</u>	Sequentially list conditions,	Due to (or as a cons	equante of).						
	ted nsit	ij	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·							
	and and	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	equence of):						
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9 ×	certifica Iding ph	Me	IF FEMALE:	3c. If yes, outcome of preg	inancv					23d. Date of del	inon,
Вох	tte Tte	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe	etal death 3	Ectopic preg				Month	Day Year
	the a	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	romann of	J Other (speci	шу)				
P.0	res that the dez igned by the a be detached fo	P	Part II. Other significant conditions con	stributing to death but not a	esulting in the u	nderlying caus	se given in Part		23a. Did tol	pacco use contribute to	the cause of death?
Ś	signe d be d	Completed by	CHRONIC OBSTR		_		-				obably 4 Unknown
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ta	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				-		Check only on		
\	\$ w p	To	1 Yes 2 No	lospital: 1 🗌 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4 🗆 N	lursing Home	5 Syleside	ence 6 Other (Spe	cify)
Division of	ding Pt T. After th funeral		27. Manner of Death 1 Satural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c	. Injury at Work?	28	d. Describe ho	ow injury occurred	
Ö	Attending r death. sector: After by the fune	atic	2 Accident investigation			М	1 ☐ Yes 2 ☐]No			
Vis	Atte	ific	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	home, farm, st	reet, factory, o	office	28	f. Location (St City or Town	treet and Number or Ri n. State)	ıral Route Number,
	al or s afte	Certification:		bundarig, oto. (ope	J., 7				,	,,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier 1 Certifying Physical (Check only one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deat ination and/or in	h occurred at vestigation, in	the time, date a my opinion, de	and place, and eath occurred	d due to the c at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	within 2 To the Comple	Me	29b. Signature and title of certifier			29c. t	icense number		2	9d. Date signed (Mont	h, Day, Year)
	F 3 F 8		mone or .	mh		D	57531		1	PRIL 11,	2007
			7	., _	00 : =						
	X		30. Name and address diverson who co	empleted cause of death (I	tem 23a) (Type,	Print)			191	citt == :	3.77
			Mohit Neg 81	ompleted cause of death (III	naturo /	1, on	u 20	7 /1	uvers	Vine my) -1108
	St Regist	ate rar	31. Date filed (Month, Day, Year)	OZ. Megistrar s Sig	,	1 10					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) .^{Day}2007 April 11, **Physician** 4:15 A M Nuncia Gellstead /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Anne Arundel Annapolis if Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, May 14, 19 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖫 F May 1914 578-16-9273 92 Washington, DC Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Edgewater Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 87 Stewart Drive 21037 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2**X X**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes ŽŽNo White Baltimore, Maryland 21215-0036 Specify: Completed by 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetologist Beauty 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Antonio Lagana Angela ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Terry Martz/ Daughter 930 Alameda Dr. Huntingtown, MD. _20639 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 4/16/2007 Suitland, MD 5 ☐ Other (Specify) 4 □Donation 21. Signature of Saneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. alus 2973 Solomons Island Rd., 21037 Edgewater. MD23a. Part 1 Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 D /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 DOA ဥ 1 🗌 Yes 1 Impatient After this funeral dir Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury at Work? Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

'n

30. Name and address of pe

31. Date filed (Month, Day,

Year)

APR 12 2007

DHMH 17 Rev 1/2001

on who completed cause of death (Item 23a) (Type Print)

Registrar's Signature

				For	State of Man		artment of I	Health and M	•	3	13656
				1 - State Ragistrar		Cei	rtificate of	Death		. No.	10000
		Physici	an	Decedent's Name (First, Middle, Last)					Date of Death Month	Day Year	3. Time of Death
4		/Medi	cal	Wallace C. Groom			41. 61. 7		April 1	1 2007	10:45 P ^M
		Examir	ner	4a. Facility Name (If not institution, give : Harford Memorial				or Location of Death		4c. County of De	
		Funeral		5. Social Security Number 6. Sec	7. Age (/	n yrs. last birthday)	If Under 1 Year		8 Date of Birth	Harf 9. B	OTCI irthplace (State or Foreign Country)
		Director		213-28-2057 ¹ X	1M 2DE	77 Yrs.	Months Days	Hours Min.	Feb. 21,	1930 M	country) aryland
		D .		Usual Residence of Decedent		0.5 T					
		anyla shov	2	10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limits 1 X Yes 2 ☐ No
		the N	Director	Maryland Harfo 10e. Street and Number	rd	Aberde	en 10f. Zip Code		100	. Citizen of What C	
		ours atter death with the Marylan rel', or Itema 23a or 28a-1 show Ezamirat must be rectified at	١٥	11 West Aztec St	root		2100	1		USA	Jounity ?
		death	Funeral		12. Was Decedent Eve	r in U.S. 13. V		Hispanic Origin? (Spi ean, Mexican, Puerto		14. Race - Arr	nerican Indian,
3	9	or Ite	F	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 📉 No				Rican, etc.)	Black, Wh	ite, etc.
2	303	arel',	d by	3 ☐ Widowed 4 🖔 Divorced	If Yes, Give Year or Dates:		1□Yes 2\X\\No	Sреспу:		Specify:	White
3	21215-0036	within 72 hours atter death with the Maryland ene. then "neturel", or Itema 23a or 28a-f show ha Medical Examinat must be redified at	Completed	15. Decedent's Edu (Specify only highest grade	cation a <i>completed)</i>	(Give	dent's Usual Occup kind of work done	during most of work	ing 16	b. Kind of Busines	s/Industry
7	12	withir ene. then	шć	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		DO NOT use retire			NT - 1 - 1	0 1
K		Hygid Hygid Other	Be Co	17. Father's Name (First, Middle, Last)		major	warenous	e Supervi	SOT a (First, Middle, Ma	National iden Sumame)	Guard
8	<u>a</u>	Mental Mental rked c	To B	Wallace Grover G	roome			Bessie I	da White		
	Maryland	s 1 and 2 should be filed within 72 hc if Health and Mental Hygiene. Item 27 Is marked other then "netun other traumatic event, the Medical		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	ng Address (Street	and Number or Rura		City or Town, State,	Zip Code)
1		and 2 ealth n 27 I		Cari Kane Groome	-			ad, Steve	nsville,	MD 21666	
0	Baltimore,	T of H		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ R	1	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other pla		5-2007	c. Location - City o	r Town, State
=	ij	t. Partmen		4 □ Donation 5 □ Other (Specify)				Home, P.	A. Ri	sing Sun	, Maryland
111/40	Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra 90cg.		21. Signature of Funeral Service I make	90	R	Name and Addre	rd Funeral	1 Home, P	.A.	
0				23a. Bart1. Enter the disease, or compli	cations that caused the			een Stree			21911 Approximate
		Dhusisian		23a. Bart 1. Enter the disease, or compli- shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	1 icolow	1	119, 32011 40 0410140 (or respiratory arrest	1	Interval Between Onset and Death
		Physician /Medical		disease or condition resulting in death)	Due to-(or as a co	onsequence of):					Tagus
190		Examiner			Kiduo	11 10,00	110)
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		and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
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	687	tificate g physi as the									
No. 1		eath certifica attending ph for use as th	J/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of p					23d. Date of de	alivery
3	.O. Box	e death he atte	icia	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim		Ectopic pregnanc Other (specify) _	у		Month	Day Year
1AC	P.0	at the d by the tached	hys	9 Unknown	9□ Unknown		10000				
1/1		The law requires that the death certifica te has been signed by the attending ph tage 2 should be detached tor use as it	Completed by Physician/Med	Part II. Other significant conditions con	tributing to death but no	ot resulting in the un	derlying cause giv	ven in Part I.			to the cause of death?
2	ecords,	w requir been s should	ted	Liver accorners	2, KING	el jan	ung		1 🗆 Yes	2 2 4√1 6 3 ☐ F	Probably 4 Unknown
2	ec	e law has b	nple			<u> </u>			24a. Was an autopsy	Drior to	utopsy findings available completion of cause of
V	E H								performe 1 ☐ Yes 2 월		s 2 No
2	ξ	sician: The la certificate ha irector, page 3	Be C	25. Was case referred to medical examiner?	ospital:		ott	26. Place of Death	N - 32 85		
ROOM	ō	Attending Physician: r death. sctor: After this certific. by the funeral director.	n: To	27. M. nn. of Death	28a. Date of Injury	2 ER/Outpatient	t 3 DOA 28c. Injui	4 Nursing Ho	me 5 Residence 28d. Describe how		ecify)
2	ion	ttending F death. ctor: After / the funer	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ea <i>r)</i> Injury		rk? Yes 2 □No		. ,	
9	Division of Vital	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (S	At home, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	at and Number or F	Rural Route Number,
		Hospital or thours after Funeral Dir tely tilled in	Cer							,	
		Hosp 24 hou Fune Fune	Medical	(Check Only 2 Medical Examir	ician: To the best of m	amination and/or inv	occurred at the tile estigation, in my o	me, date and place, a opinion, death occurr	and due to the caused at the time, date	se(s) and manner a and place, and du	is stated. le to the cause(s)
		To the Hospital or Attend within 24 hours after death To the Funeral Director: completely tilled in by the	Med	29b. Signature and Ville of certifier	and manner stated		29c. Licens		29 d		
		6 ਜੋ≮ ਜ		M	(1) X	0		62765		12/280	7
		0		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type I	Print)	24/00	//	1000	
		0		NESREEN KUE	^ -	501 5	. UNIOI	J Ave	HAVrea	le GRAC-	e Mz 21078
		Sta		31. Date filed (Month, Day, Year) APR 1 3 2007	32. Registrar's	Signature					
		Registr	ar	T 9 (00)	NEWSON NO	- ANDREAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Earl Lincoln Glassman 0326 4pril 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel-Air Harford Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**⊠**M 2□F Months Days Hours Min 78 Yrs. 212-30-7414 02, 12, 1929 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 NYYes 2 □ No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 620 N. Adams St 21078 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗆 No 1946-1 ☐ Yes 2 🛣 No White Specify. 3 Widowed 4 Divorced 1951 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Alfred Glassman Jeanette (Curry) Glassman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Northway Havre de Grace, Maryland 21078 Janet Dill (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gardens 4,26,2007 Aberdeen, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A MOJ 123 S. Washington St. Havre de Grace, MD 21078 Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS SYNDROME Due to (or as a consequence of): SEPTIC APTHRITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🗓 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 □ Yes 2 □ No

40657 <u>م</u> cate has been signed page 2 should be det Record certificate Vital 2 assman

or Attending

funeral director, after death filled in by within 24 hours a

To the Funeral I

Physician/Medical Examiner

Medical Certification: To Be Completed by

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Director

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is 1 and 2 should be fill. Health and Mental H tem 27 Is marked ott

Pages 1

ortant: If Item 2

permit. Page Department o Important: If any injury or

Physician

/Medical

Examiner

RENAL FAILURE, CORONARY ARTERY DISEASE ATRIAL B'BRILLATION 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 5 ☐ Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier William SURESH DHANJANI

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESH DHANJANI 622 S. UNION AVE, HAVRE DE GRACE, MD 21678

A 45344

State Registrar

completely

31. Date filed (Month, Pay, Year) 32. egiştrar's Signature 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 10, ^{Day} 2007 **Physician** Richard Z. Hricak 6:00 a M /Medical 4b. Cify, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 10303 Lloyd Road Potomac Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Jan. 20, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 M 2 □ F Jan. 069-30-7558 75 1932 Belgium Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10303 Lloyd Road 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2□No Specify Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Entrepreneur Window Film 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ziri Hricak Anna Kopic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Astrid A. Hricak-Spouse 10303 Lloyd Road, Potomac, MD 20854 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 ☐Removal from State Parklawn Memorial 4-16-2007 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute, 1040 Rockville Service Lige 21. Signature of Funeral Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung Cancer resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner bunal-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No been signed by the a should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by HRICUK, Kichard Z 2 No 3 Probably 4 Munknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 XNo 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient ours after death.

neral Director: After this

filled in by the funeral di Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

12

State Registra

Genevieve Wrobleski, 31. Date filed (Month, Day, Year)
APR 1 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signatura and title of certifier

MD 1355 Piccard Drive, Suite 32 Registrar's Signature

mi

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

4-11-2007

100, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 8:10 P April 2007 Robert B. Hill 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 5. Social Security Number 1☑M 2□F 14, 579-48-2594 76 Sept. 1930 Kentucky Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State 11 Yes 2 No MD Bethesda Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number #1601 20816 United States 5101 River Road Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Allier Possi 1 Dyes 2□Nº Korean If Yes, Give Year or Dates: War 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced War 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) IBM Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carol B. Hill Kathaleen Oldham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5101 River Road #1601 Bethesda, MD 20816
ce of Disposition (Name of Date 20c. Location - City or Town, State Gail Forman Hill / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/14/2007 Falls Church, VA National Crematory 21. Signature of Fundral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re-pirate arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death disease or condition resulting in death) Subdural Hematoua, Acute Due to (or as a consequence of): Fall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hour) that initiated events Due to (or as a consequence of resulting in death) Last Due to (or as a consequence of u 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 I I Inknown 23e. Did tobacco use contribute to the cause of death? Anticoagulation For Cardiac Arrhythmia (Atrial 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Fibrillation) autopsy 1 Yes 2 No 26. Place of Death (Check only one) Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1X Yes 2 No 1 XInpatient 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he activate the activate that the Medical Examiner must he activate the activate that the medical Examiner must he activate the activate that the medical Examiner must he activate the activate that the medical Examiner must he activate the activate that the medical Examiner must he activate the activate that the same that the activate

Baltimore, Maryland 21215-0036

Examine and burial-trar The law requires that the death certificate be execu attending physician Physician/Medical the as use for the To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F.

Division or Vital Records, P.O. Box 68760.

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 25. Was case referred to medical examiner? ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☑ No 04/05/2007 9:00 A Fell next to bed 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State 5101 River RD #1601 3 Suicide determined 4 Homicide At home Betchsda, MD 20816

1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner: **On the basis of examination and/or investigation, in my oninion, death occurred at the time date of the cause (s) and manner as stated. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

manner stated. 29a. Certifie

State

29b. Sig

Medical

29c. License number

29d. Date signed (Month, Day, Year)

4/13/2007

of death (Item 2 a) (Type, Print) and address of ersor

Ronald H. Uscins 18111 Prince Philip Dr. #310 Olney, MD 20832

31. Date filed (Month, Day, Year) 2007 APR 13

32 Registrar's Signature

Registrar

			For State Registrar	State o	f Marylai	nd / Depa		t of H	ealth	and M	lental Hy			13660		
	Dhusiai		1. Decedent's Name (First, Middle,								2. Date of Do Month	eath Da	y Year	3. Time of Death		
	Physici: /Medic		Catherine Lucil								April 8	3, 20	007 County of Death	11:30 A ^M		
if	Examin	er	4a. Facility Name (If not institution, g						Location							
			Holy Cross Nursi 5. Social Security Number 6	ng & Ren		ation . last birthday)			sv11		8. Date of Bi	rth	Montgomery b. 9. Birthplace (State or Foreign			
	Funeral Director		212-22-0260	1 ☐ M 2 🖾 F	87	Yrs.	Months	Days	Hours	Min.	April	4, Year)	920 Penr	nsylvania		
	pu ,		Usual Residence of Decedent 10a. State 10b. County		100 0	lity. Town or Lo										
	laryla ehov	7	,	e George		Hyattsv								10d. Inside City Limits 11 Yes 2 □ No		
	the N	rect	Maryland Princ 10e. Street and Number	e George	5 1	ilyattsv	10f. Zip	Code				10a. Cit	izen of What Cou	ntry?		
	3e or	i D	4316 Kennedy St	reet					781				USA			
	death	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U	U.S. 13.	Was Deced	lent of Hi	spanic Or	igin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Race - Ameri Black, White,			
36	or It	y Fu	1 Never Married 2 Married	1 ☐ Yes If Yes, G	2 🖾 No ve		1 ☐ Yes		Specity.		, , , , , , , , , , , , , , , , , , , ,			hite		
Ö	hours furel	Completed by	3 ☑ Widowed 4 □ Divorced 15. Decedent's	Year or E)ates:	16a. Dece	dent's Usua	I Occupa	ation			16b K	ind of Business/Ir	ndustry		
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212	d with giene er the	Com	8	College (1-401 5+/	Но	usewi	fe				Ow	n Home			
ם	be file tal Hy d oth	Be (17. Father's Name (First, Middle, La						18. Moth		e (First, Middle		Sumame)			
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other them 'neturel', or Items 23e or 28e-f ehow eumetic event, the Madical Examiner must be notified at	To	Unavailab								availab					
<u>a</u>	d 2 sh th and 17 is n treun		John Hoff - Son					•			verdale		or Town, State, Z_{ij} 20737	o Code)		
<u>စ</u> ်	s 1 and 2 should of Health and Men item 27 is marke other treumetic		20a. Method of Disposition		20b.	Place of Dispo	sition (Nan	ne of	T		Date		ocation - City or T	own, State		
Baltimore,	permit. Pages Department of I Importent: If ite eny injury or of		1 ABurial 2 □ Cremation 3 4 □ Donation \ 5 □ Other (Spe		State For	cemetery, crei rt Linc	oln C	eme t	ery	4/13	/2007	Bren	twood, M	laryland		
a	permit. Departm Importe eny inju		21. Signature of Funeral Service Liv			22	2. Name an	d Addres	s of Facili	ity		4	739 Balt	imore Ave.		
<u> </u>	20 = 8		dust	Mac		G	asch'	s Fu	nera	l Hon	ne, P.A	. H	yattsvil	le, MD 2078		
Ü,			23a. Parti. Enter the disease, or co shock, or heart failure. List or	ly one cause on	each line.		er the mod	e of dying	g, such as	cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death		
1	Priysician		Immediate Cause (Final disease or condition resulting in death)	a	sis syı											
	/Medical Examiner				(or as a conse umonia	quence of):										
	14 1	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	(or as a conse	quence of):										
	outed Id ansit	Examiner	that initiated events	c												
,097	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to	(or as a conse	quence of);):									
∞	physic physic the bi	dlcal		d.	_			-								
9 ×	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	/Med	IF FEMALE:	23c. If yes, ou	tcome of pregr	nancy							23d. Date of deliv	I PO		
Вох	atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1☐Live 4☐Preg	ointh 2☐Fet mant at time of	tal death 3	Ectopic pro Other (sp						Month	Day Year		
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	res that igned b	ру Р	Part II. Other significant condition	•		•	nderlying c	ause give	en in Part	l.		_	_	the cause of death?		
ord	w require been sign should b		Dementia, fai	lure to	thrive	3					1 🗆	Yes 2	No 3 Pro	bably 4 □Unknown		
Records,	e taw r has be je 2 sh	Completed	Dysphagia								24a. Was	psy	prior to co	opsy findings available ompletion of cause of		
											1 ☐ Yes		death?	2 No		
X		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	☐ ER/Outpatier	2000	Othe			h (Check only		6 □Other (Speci	(6.1)		
0	g Phye er this eral di	\vdash	27. Manner of Death		of Injury eth, Day Year)	28b. Time o	_	8c. Injury	at	-	28d. Describe			97		
0	ath. rr: After ne funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	ion	un, Day rear)	Injury	М	Work	Yes 2	No						
Division of Vital	r Atte ter de irecto	Certification;	3 Suicide 6 Could no 4 Homicide determin	286. Place	of Injury - At h	home, farm, str	eet, factory	, office			28f. Location City or To		nd Number or Rur e)	al Route Number,		
	o the Hospitel ithin 24 hours a o the Funerel I ompletely filled	Medical		aminer: On the b) and manner as s d place, and due t			
	To the Hospitel within 24 hours a To the Funerel I completely filled	Mec	29h Signature and title of certifier	-			290	. License	a number			29d. Da	te signed (Month,	Day, Year)		
)			> 1. Juya	meur	dow		S	D5	3367			4	/9/2007			
	(t)		30. Name and address of per on wh					-30-7								
	3		Dr. Rajan, 34				te 10	5, 0)lney	, MD	20832					
	Sta Registr	_	31, Date filed (Month, Day, Year)	seem 32.	Registrar's Sign	iature										

State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Hardtke Clara Α. 9:20 AM Apr. 10, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery National Lutheran Home Rockville 8. Date of Birth (Month, Day, Year)
Tuly 22,1916-Illinois 5. Social Security Number If Under 1 Year | II Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 M 2 XF 90 335-05-3206 Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits !7 is marked other then "natural", or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Md. Montgomery Rockville 1 X Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9701- Veirs Drive 20850 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or iteme 11. Marital Status Black, White, etc. 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Decupation 16h Kind of Business/Industry 15 Decedent's Education permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other then "na ery injury or other traumatic event, Tra Madis 2008. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary DeLeuw-Cather 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick Hardtke Antonia Wlcek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Palm/ NIECE 7864 Vervain Ct., Springfield, Va. 22152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Concordia Cem. 4/21/2007 Forest Park, Ill. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2222-Wisconsin Ave., NW Hysong Co., Inc. W. Wash.

23a. Part1. Enter the disease, or tori plications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Wash., DC 20007 Immediate Cause (Final Physician disease or condition resulting in death) STANE DEMENTA /Medical Due to (or as a consequence of): Examiner AILURE TO THULVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner ed by the attending physicien and detached for use as the burial-transit certificate be executed DIADETES M Due to (or as a consequence of): MELLITUS resulting in death) Last Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. F 1 ☐ Yes 2 No 9 Unknown 9 Unknown cate has been signed by topage 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has Division of Vital 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death Check only one examiner Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide 25/a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the nawee(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nheine APRIL 1D 2007 D0051158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 20850 ROCKVILLE ANTHONY 9701 VEIRS DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 13 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 2007 Horace Palmer Haithcock

7. Age (In vrs. last birthday,

4b. City, Town, or Location of Death

Lanham

9:42 A

9. Birthplace (State or Foreign

21226

Approximate Interval Between Onset and Death

Year

4 Unknown

1X Yes 2 □No

4c. County of Death

Prince George's

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)

Social Security Number

Doctors Community Hospital

Funeral Director death with the Maryland r 28a-f show notified at

Director

Funeral

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Completed

Be 2

Exami

Physician/Medical

Completed

Be

Certification:

Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If flem 27: is marked other than "natural", or items 23a or : any inlury or other traumatic event, the Medical Examiner must be a

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

and burial-trar attending physician for use as the buria ed by the detached has certificate pletely filled in by the funeral director. after death. Director: After To the Hospital within 24 hours a

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division or Vital

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if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex_ 1 XM 2 ☐ F 8. Date of Birth (Month, Day, Year) 1917 North Carolina 227-18-4701 89 15, Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits Bowie MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 USA 12733 Haskell Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2 🗓 No Specify. Specify: White 3 Novidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry District of Columbia Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Metro Transit 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Whitney Haithcock Viola Mae Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Greenland Beach Rd. Howard S. Haithcock / Son Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem. Gardens 04/17/2007 | Davidsonville, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Malignant cardiac arrythmia Due to (or as a consequence of) Diabetes Mellitus Sequentially list conditions, in any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Hypertension Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 12, 2007

Registrar

State

300

7525 Greenway Center Drive

Greenbelt, MD.

20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Cecil D. George, M.D.

31. Date filed (Month, Day, APR 13 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Wilma Lee HOOVER 200 Dri /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X F Director 214-28-1057 76 March 10 1931 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√☐ No Director W. Va. Berkeley Falling Waters 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 161 Ditto Farm Drive 25419 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No It Yes, Give Year or Dates: 1962-84 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify. 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Mearl R. Godlove Lawrence W. McGowan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1183 Grade Road, Falling Waters, W.Va. 25419 Lawrence McGowan - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 4/19/07 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Fred Lil 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MeTastatic Small Cell undifferentiatel **Physician** /Medical Due to (or as a consequence of): **Examiner** Carcinama -ung if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed bunial-transit and Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnan 3 ☐ Ectopic pregnancy in the past 12 mont Month Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown eage 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' this certificate 2010 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Yes 2 | 1 | 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To nours after death.

neral Director: After this

filled in by the funeral d 28a. Date of Injury 28b. Time of 27 Manner 28d. Describe how injury occurred 28c. Injury at Work? 1 Julianural 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours
To the Funeral 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) unn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 (

6+1

State Registrar DHMH 17 Rev 1/2001

Year) 31. Date filed (Month

Hancisco

32. Registrar's Signature

Vaurels

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day 200^{Year} 9, 4:35 P M April Eugene Perry Hardesty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Calvert Prince Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, 1 X M 2 □ F Months Days Hours Director 01-28-1921 Maryland 217-16-6674 86 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at Director 1 ☐Yes 2 No Friendship Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 6845 Old Solomons Island Road 20758 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Styes 2 Not 1942–45 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: ρ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Health and Mental Hygiene. cabinet maker 11 US Treasury Dept 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sr. Eugene Perry Hardesty, Myrtle Annie Stallings 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i P.O. Box 123, Friendship., MD Evelyn K. Hardesty, spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Friendship Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 04-13-07 Friendship, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 320 8325 Mt. Harmony LAne, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Due to (or as a consequence of): **Physician** /Medical Examiner Obstructive Pulmonary disease hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Bladder cancer 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 s autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after decral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated.

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ADEEB

MD

JABER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

12

2007

HOSP ITAL

32. Registras Signature

RO.

29c. License number

060390

PRINCE FREDERICK

29d. Date signed (Month, Day, Year)

109

Galen Andrew Ha	-		ate of Maryland	I / Depart		Health an				07 13665	
Physicia	_	Registrar 1. Decedent's Name (First, Middle	e,Last)	Certi	ilicate of	Dealii		2. Date of Dear	eg. No.	-3. Time of Death	
Medical Examir	ner	Galen Andrew Ha				0 T	,	Month April 22, 2		1025 hrs	
	П	 Facility Name (if not institution 997 Highpoint Drive 	n, give street and numbe	r)	'	Annapolis	r Location of Dea	tu	.4c. County of I Anne Arur		
Funeral		5. Social Security Number	6. Sex 7. A	ige (In yrs. las	t birthday)	If Under 1 Yea				9. Birthplace (State or Foreign	
Director	L	220-25-2941	XX M 2 F	1	17 Yrs	Months Day	ys Hours Mi	n. 1/14/	1989	Country) MD	
k k	- 1	Usual Residence of Decedent 10a. State 10b. County	-	10c. City, T	own or Locati	on	<u>-</u> .			10d. Inside City Limits	
show a	٦	MD Anne A	Arunde1	Annap	olis					1 Yes 2 X No	
Maryla r 28a-f	Director	10e. Street and Number	3.00			10f. Zip Code	400	1	0g. Citizen of What	•	
sath with the Maryland items 23a or 28a-f show any ast be notified at once.	ra D	1898 Dulany Pla	12. Was Decede	nt Ever in IIS	113 Wa		409	Specify Yes or No	USA lo- 14. Race - American Indian, Black,		
Jeath w	al	1 X Never Married 2 Ma	arried Armed Force				n, Mexican, Puer		White,		
after crall', or	Ā.		orced If Yes, Give Year			Yes 2X No			Specify:	White	
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18. Mother's N Stephen Blaine Clare									Maiden Surname)		
Stephen Blaine Clare Harig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St.										State, Zip Code)	
Stephen Blaine Father 1898 Dulaney Place Annapolis, MD 21409											
20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City Crematory or other place)											
timent rtment y or ot		4 Donation 5 Other Sp 21. Signature of Funeral Service		Lake		Iem Gard Iame and Addres	a of Facility		1	ville, MD	
Bal perm Depa Impo injur	-	27 3 J. O	Licensee		100		Па		Funeral H MD 2140	ome, P.A.	
Physician		23a. Part I. Enter the disease, or failure. List only one cause		ed the death. D	Do not enter t	ne mode of dying	, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and	
/Medical Examiner	İ	Immediate Cause (Final disease or condition resulting in death)	a. Acute alcol			1				Death	
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	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	sequence of):							
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68760 certificate b nding physise as the bu	ŝŀ	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outo		ancy			nancy	23d. Date of de	elivery Day Year	
x 68 th certi	siciar	past 12 months?	4 Pregnant	at time of deat	h -	tal death 3 her (Specify)	copic preg	inancy	World	Day	
the death c	Phys	1 Yes 2 No 9 Unk	9Unknown	ath hut not res	ulting in the I	inderlying cause	given in Part I	23e. Did to	obacco use contribu	ute to the cause of death?	
of Vital Records, P.O. Box 68760 ing Physician: The law requires that the death certificate to After this certificate has been signed by the attending physiumeral director, page 2 should be detached for use as the burneral director, page 2 should be detached for use as the burneral director.	<u>a</u>	Tarkin Still Significant Solicit	ions contains any to do	att bat not res	ording in the c	inderlying dadde	givoirii i diti.			Probably 4 Unknown	
of Vital Records, g Physician: The law requir ther this certificate has been is neral director, page 2 should I	Completed							24a. Was		ere autopsy findings available or to completion of cause of	
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tal Rec	8	25. Was case referred to medical examiner?	Hospital				e of Death (Chec				
of Virginia Physician terthis	۵	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Ir		ER/Outpatient 28b. Time of I		Other Nurs	28d. Describe	Residence 6 how injury occurred		
Sion of Vitending Ph death. ctor; After t	tion	1 Natural 5 Pend	ding Find / /2	/,Year)	Fnd 10:	1	Yes 2 X No	unk	, , , ,		
Division tal or Attendi rs after death. al Director;	ertification:	3 Suicide 6 X Coul	d not be 28e. Place of	Injury - At hon	ne, farm, stre	et, factory, office	building, etc.	28f. Location (Street and Number. State) 997 Hig	or Rural Route Number, City	
ospital hours meral ly filled	Find 4/22/2007 Find 10:15 am 1 Yes 2 X No unk 2 Accident 3 Suicide 4 Homicide 6 X Could not be determined 6 X Could not be determined (Specify) found in parked vehicle 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state.										
FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. if yes, outcome of pregnancy 1											
F > F 3	ž	29b. Signature and title of dertifie		1			se number			(Month, Day, Year)	
	ļ	HIM	VI		12-)	0.0	.M.E. 		April 23, 200	1	
104	۱ ا	30. Name and address of purson Susan Hogan MD.	who completed cause of Assistant Medical I			n Street, Bal	Itimore, MD 2	1201			
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			1 - For State State Registrar		artment of Health and I rtificate of Death		iene 2007	13666
s .	Dhusisi	J.	Decedent's Name (First, Middle, Last)			2. Date of Deat Month		3. Time of Death
	Physici /Medio		Scott Ferney Imirie Jr		1	April 1	1, 2007	4:50 P
	Examir	ner	4a. Facility Name (If not institution, give street and 3813 Williams Lane	number)	4b. City, Town, or Location of Deatl Chevy Chase	٦	4c. County of Dear	
	Funeral	-	Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Bin	hplace (State or Foreign
	Director		579-16-6846 ¹ XI ^M ² □F	83 Yrs.	Months Days Hours Min.	04/24/19	923 Wasi	nington, DC
	and ww		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
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	th the	Director	10e. Street and Number		10f. Zip Code	10	0g. Citizen of What Co	ountry?
	ath wi	rai	3813 Williams Lane		20815		nited State	
_	ter de Items iner m	Funeral	Armed	ecedent Ever in U.S. Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
2-003p	al", or	by	If Yes.	Give r Dates: 1946	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh:	ite
2	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade complete	d) (Give	dent's Usual Occupation kind of work done during most of wor	rkina	16b. Kind of Business	,
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ıand	Aental rked or	To Be	Scott F. Imirie Sr.		Olive L	. Meyer		
Mar	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. I Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show item 27 is marked other than "nature traumatic event, the Medical Examiner must be notified at	ľ	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street and Number or Ru	ıral Route Number	, City or Town, State, .	Zip Code)
e, e	1 and Health sm 27 ther t		Elizabeth Pilson Imirie 20a. Method of Disposition		Williams Lane Ch		e, MD 2081:	
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ранито	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra		21. Signature of Funeral Service bicensee	Arlington	Nat. Cemet.: 720 2. Name and Address of Facility Jo		**	
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ב	pital o		29a. Certifier 1 Z Certifying Physician: To	the hest of my knowledge deat	h occurred at the time, date and place	and due to the c	ause(s) and manner a	s stated
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examiner: On th		exestigation, in my opinion, death occi			
	withir	Me	29b. Signature and title of certifier	2	29c. License number	2	9d. Date signed (Mon	th, Day, Year)
	15		Futuch St	LON MA	D22775	A	pril 12, 2	2007
			30. Name and address of person who completed of			-	00017	
	Sta	ate	Frederick G. Barr MD 54 31. Date filed (Month, Day, Year) 32	+D4 Wisconsin A Registrar's Signature	Nve. #1300 Chevy (Chase, MD	20815	
	Registi	rar	APR 1 3 2007	Registrar's Signature	and I			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State
Registrative ND#23aperMD4/17/07, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:38 P™ Constance James March 26, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 ☐ M 2 🖾 F 352-20-4947 80 30,1926 Alaska Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits 1 Yes 3 No Takoma Park Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20912 United States #117051 Carroll Avenue, 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 至文No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ▼ No Specify: Specify 3 ☐ Widowed 4 St Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Unknown Unknown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Fort Lincoln Crematory Unknown Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Furteral Septice 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 Pan Enter the disease, shock, or heart failure. complications that caused the arath. Do not enter the mode if dying, such as cardiac or respiratory arrest, only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypoxia Due to (or as a col Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence resulting in death) Last Due to (or as a conseque 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 1. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown

Physician /Medical Examiner

permit. Page Department of Important: If any Injury or once.

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 ie marked other than "naturel", or Items 23e or 28e-f ehow

Baltimore, Maryland 21215-0036

Item 27 is marked other than "naturel", or items 23s or 28s-f show other treumatic event, it is Madical Examinar must be multipled at

/Medical

Director

Completed by Funeral

Be

2

Examiner

Completed by Physician/Medical

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Certification:

Medical

Physician: The law requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit hes

this certificete funeral director, After s after dec.

Division of Vital Records, P.O. Box 68760,

or Attending

within 24 hours a To the Funeral C

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 🗹 No

examiner

27. Many r of Death 1 Natural

2 Accident

3 🗀 Suicide

29a. Certifie

4 T Homicide

(Check only one)

1 ☐ Yes 2 No

Part II.	Other	significa	int cond	litions o	contribut	ing to de	eath but i	not result	ing in the	underlying	cause g	given in Par

25. Was case referred to medical

Hospital: 1 Inpatient 2 LER/Outpatient 28a. Date of Injury (Month, Day Year) Injury

3 DOA

Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

1 Yes

26. Place of Death (Check only one)

2 No

28d. Describe how injury occurred

29b. Signature and title of certifier

29c. License numbe

29d. Date signed (Month, Day, Year) X

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and officess of person who completed cause of death (Item 23a) (Type, Print)

DR. NASREEN -7600 Carroll Avenue, Takoma Park, Maryland' 20912 KANGO 31. Date filed (Month, Day, Year)

State Registrar

APR 13 2007

5 Pending investigation

6 Could not be determined



			For State	State of Maryl		artment of F			2001	13668	
			Registrar 1. Decedent's Name (First, Middle, Las	(t)		Timouto or i	Doutin	2. Date of Death	g. No.	3. Time of Death	
	Physic			1				Month	Day Year	ам	
k.	/Medi Examir	1 No.	<u>Duncan</u> James Ja 4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	April 9,	2007 4c. County of Deat	4:36	
		lei	Washington Advent	ist Hospita	L yrs. last birthday)	If Under 1 Year		8. Date of Birth	Montgo 9. Birt	hplace (State or Foreign	
left.	Funeral Director		-	□M 2□F	74 Yrs.	Months Days	Hours Min.	(Month, Day,		th Carolina	
	land ow		10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits	
	Mary Fied	to	Maryland Prince (George's E	Hyattsvi	11e				1 □Yes 2X No	
	h the	irec	10e. Street and Number	·		10f. Zip Code		10	g. Citizen of What Co	ountry?	
	th wii	al [1504 Amherst Road			2078	33		US	A	
	r dea	Maryland Prince George's Hyattsville Maryland Prince George's Hyattsville									
980	ours afte ral", or it Examin	l by Fi	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	orean	1 ☐ Yes 2 ☐xNo	Specify:		Specify: Wh	Vhite, etc. Vhite	
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation	1 16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	oation during most of worl d)	king 1	6b. Kind of Business/	Industry	
212	d with giene gr tha	Reta	ail								
	0 = 0 5	Be (17. Father's Name (First, Middle, Last)	e (First, Middle, M	laiden Surname)						
<u>la</u>	Ment Ment arked	70	Duncan Jackson,	1							
Maryland	nd 2 should be filed with and Mental Hygie 27 is marked other the traumatic event, the		19a. Informant's Name/Relationship (Huguette Simon	**					City or Town, State, 2		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic esonce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Hemoval from State		osition (Name of matory or other place	1	ril 16	20c. Location - City or		
薑	it. Partmen		4 □ Donation 5 □ Other (Specification 21. Signatur of Funeral Service Licer	<u>′</u>		Heaven Ce				ing, Maryla	
Ba	Depa Impo any I		21. Signature of different Service Licer	10000					Home Inc.		
-	_		23a, Part1, Enter the disease, or com	lications that caused the	leath. Do not en	OO Univer ter the mode of dvir	rsity Blv ng. such as cardiac	or respiratory arre	ilver Spri	ng, MD 2090 Approximate	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		,	3,	, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death	
f.	Physician /Medical		disease or condition resulting in death)	a. Emphysema Due to (or as a cor						Unknown	
	Examiner			Pneumonia						Unknown	
	-10.5	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor						OHRHOWH	
	icate be executed physician and s the burial-transit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events	C							
o,	cate be executed oblysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a cor	sequence of):						
8760,	te be tysicia ne bu	dical		d							
9	ng ph	Med	IF FEMALE:								
. Box	The law requires that the death certific ate has been signed by the attending proage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3[□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	livery Day Year	
P.0	at the by the	hys	9 ☐ Unknown					1			
Records, I	tuires that the de n signed by the a lid be detached i	Completed by F	Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	ınderlying cause giv	ven in Part I.		acco use contribute to s 2 □ No 3 □ P		
S	w requir been si should I	lete						24a. Was ar	24b. Were a	utopsy findings available	
Re	he lav e has age 2	ш						autopsy	ned? death?	completion of cause of 2 □ No	
Vital	an: T tifficat or, pa		25. Was case referred to medical				26. Place of Dea	1 Yes 2 th (Check only one	2. [2\$No 1 ☐ Yes	2 140	
>	Physician: The la r this certificate had ral director, page 2	To Be	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient	2 X ER/Outpatie	nt 3□ DOA Oth			nce 6 □Other (Spe	ecify)	
S S S S S S S S S S S S S S S S S S S											
Signatural 5 Pending (Month, Day Year) Injury Work? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No No No No No No No											
Division	er de recto	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - building, etc. (Si	At home, farm, st	reet, factory, office		28f. Location (Str. City or Town	reet and Number or R , State)	ural Route Number,	
	ital o	Cer									
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medical Example 12 Medical Example 2 Medical Example	ysician: To the best of my niner: On the basis of exa							
	the Ihin 24 the F the F	Medical	one)	and manner stated.		29c. Licens					
	5 ¥ 6 00 00 00 00 00 00 00 00 00 00 00 00 00	-	29b. Signature and title of certifier)			57692		9d. Date signed (Mon	Day, 18al)	
	10+1			J MI)			11016		1/11/0	T	
	10		30. Name and address of person who				Takoma D-	mle MD 0/	2012		
			Dewry J. White, I	1.D. 7600 (Avenue, T	гакота Ра	rk, MD 20	J312		
	St	ate	31. Date filed (Month, Day, Year)	07 Segistral S	La d	2					

			1 - State Registrar		Death	Reg. No. 2007 366						
	₹. 3 a		1. Decedent's Name (First, Midd	le, Last)					2. Date of Dea		V-0-	3. Time of Death
	Physicia		ROBERT	LEE	JAMES	SR.			APRIL	7 200	Year 7	9:00 A M
*	/Medic Examin	_	4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, or	r Location of Death		4c. County		
		# · · ·	WASHINGTON A	OVENTIST 1	HOSPITAL		TAF	KOMA PARK		MONT	GOMER	Y
	Funeral	9.7	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h v. Year)	9. Birthp	lace (State or Foreign
	Director		249-34-4083	t X M 2□F	73	Yrs.	World is Days	Tiodis Will.	JULY 16	5 1933		H CAROLINA
1111	P.		Usual Residence of Decedent		1.0							
	nylar show I at	_	10a. State 10b. Count	,	10c. Gr	ty, Town or Lo	ocation				1	0d. Inside City Limits
	h the Marylan r 28a-f show i notified at	cto	MD PRING	CE GEORGE	'S H	YATTSV	ILLE					M_Tes 2 No
	th th or 28 e no	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	th w 23a ust b		3450 TOLEDO	TERRACE	# 517		2078	32		U.S.A		
	ems er m	Funeral	11. Marital Status	Armed F	cedent Ever in U Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,	
õ	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Ma	If Yes. G	Give	RMY	1 ☐ Yes 2 █ No	Specify:		Specif	v: B	LACK
2-0036	ours Jral",	d by	3 ☐ Widowed 4 ☐ Divorce		Dates:					eenevie.		
Ţ.	72 h "natu dica	Completed	15. Decede (Specify only high	nt's Education est grade completed	1)	16a. Dece	dent's Usual Occup	ation during most of work d)	ring	16b. Kind of B	usiness/In	dustry
	vithin ne. han e Me	m m	Elementary/Secondary (0-12)		(1-4or 5+) 2 +	me.		3)		COM	IZ IO NIMEE	NED
7	filed v Hygie ther i		17. Father's Name (First, Middle		<u> </u>		PRINTER	18. Mother's Nam	a /Firet Middle		ERNME	IN I
S C	be do do	Be	AARON JAMES	, Lasi)					IE OLIVI		110)	
$\frac{3}{5}$	should be and Menta marked umatic ev	٩		10. (T D.(.))		405 14-10					01-1- 7:-	0-1-1
Maryland	2 s ar is		19a. Informant's Name/Relation					and Number or Rui				,
	s 1 and if Health item 27 other ti		BETTY J. JAME	S/WIFE	20h		TOLEDO 7. osition (Name of	<u>ΓERRACE #</u>	517 HYA	ATTSVIL 20c. Location		
0	0 0		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from	n State	cemetery, cre	matory or other plac	ce)			•	
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ga	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee		2	2, Name and Addre		J. B. JI			
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			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the dea each line.	th. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician	î î	Immediate Cause (Final disease or condition	aCI	4RD10	ulm	DreARY	ARRE	ST			Oriset and Death
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	e death he atten ed for u	sici	1 ☐ Yes 2 ☐ No	4□Pre 9□Unk	gnant at time of	death 5[Other (specify)				OHUI	Day Tour
J.	The law requires that the death certific te has been signed by the attending p rage 2 should be detached for use as	Physician	9 🗆 Unknown						00- Did4		4-71444	he cause of death?
	es th ignec	by	Part II. Other significant condit	ions contributing to	death but not res	suiting in the u	inderlying cause giv	en in Part I.				
פ	w requires to been signer should be o	ted							101	res Zpano	3 🗀 Proi	bably 4 ∐Unknown
Records,	law r as be 2 sh	ple							24a. Was		Were auto	ppsy findings available impletion of cause of
	The ate his page	Completed								rmed?	death?	2 ⊠ No
VIta	ıysician: The lavis certificate has director, page 2	Be C	25. Was case referred to medic	al				26. Place of Dea	th (Check only o			
	nysic nis ce direc	ToE	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 15	Inpatient 2] ER/Outpatie	nt 3□ DOA Oth	ner: 4 ☐ Nursing H	ome 5 🗆 Resid	dence 6 Otl	her (Speci	fy)
Division or	ding Phys h. After this funeral dii		27. Manner of Death 1 Matural 5 ☐ Pend	/8.4.	e of Injury onth, Day Year)	28b. Time o	of 28c. Injui	ry at rk?	28d. Describe h	how injury occur	rred	
<u> </u>	Attendir death. cctor: Al	atio	2 ☐ Accident inves	igation				Yes 2 □ No				
<u>S</u>	or Atten after death Director: in by the	ific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	-: nad 200. Fid	ce of injury - At h	ome, farm, st	reet, factory, office		28f. Location (5	Street and Num vn, State)	ber or Run	al Route Number,
5	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific pompletely filled in by the funeral director,	Certification:		l l								
	To the Hospital within 24 hours a very to the Funeral be dompletely filled			ng Physician: To t I Examiner: On the								
	the H in 24 the F	Medical	one)	and ma	anner stated.							
	N Pop	Σ	29b. Signature and title of certifi	er A. A			29c. Licens	se number		29d. Date signe	ed (Month,	Day, Year)
	(12)		physpay	9 M)			104	0529		MKIL	-9	100+
	(/mp		30. Name and address of perso	who completed ca	use of death (Ite	m 23a) (Type,	, Print)		0 0 ===	10-1-	0000	
	J.W.C		VICIOR ON	YGIAKA	+325	A HAY	YOVER A	ARKWAY!	GREEN	BEG 1	VIHEY	(AND 20770
	Sta		31 Date filed (Month, Day, Yea AFR 1 3 2007	32.	Registrar's Sign	ature						
	Registi	ar	-11 11 2 0 2001	Marken .	M. Sp	a .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 0850 M bourne OT /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hartiey Social Security Number NURSine Focomula C14
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. worcester Home Birthplace (State or Foreign Country) 6. Sex (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) 1 ☐ M 2 XF Yrs 168-26-256 Usual Residence of Decedent Director the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other then "naturel", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at Yes 2 □ No Director Wirceste Comohe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 SI States 85 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturel; or item any injury or other traumatic event, the Medical Examples. 1 ☐ Yes ZX No If Yes, Giva Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify þ **T** Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) emestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jeffersin 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21851 borine (rephus) DON416 2429 Stackton pocomote 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 07 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2336 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CEREBROVASCULAR A aute /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 **2**(Vo 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2.200 certificate has 20 No 1 Yes 1 ☐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 3□ DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending Injury 1 Alatural 5 Pending death 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

BA 5

Division of Vital Records, P.O. Box 68760

ORIGINAL

1604

MI)

SATYAL,

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

R

SHARAD

31. Date filed (Month, Day, Year)

0062172

MARICOT ST

POLOMOKE MO

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month William Joseph Knott 3:23 p^M April 6,2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3433 Peerless Place Bryans Road Charles If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 220-42-0487 61 16,1945 Maryland **Director** May Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits jiene. r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 □Yes 2 No Director Maryland Charles Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3433 Peerless Place U.S.A.

14. Race - American Indian, 20616 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Clerk marked other traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Joseph Knott Mildred Irene Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas H. Knott 128 Toronada Drive, Martinsburg, WVa 25403 Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Funeral Service Alexandria, Va. 21. Signature of Funeral Salvice Dcensee 22. Name and Address of Facility Williams Funeral Home, P.A. 20640 M00668 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, I an Head Appr C ate. List only one cause on each line. 23a. Part1. Enter the diseashock, or heart failure Immediate Cause (Final disease or condition resulting in death) Physician Ischemic Heart Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9☐Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1/√Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Injury at Work? Hospital or Attending 1 Natural 5 Pending investigation death. 1 □ Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0050883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swines-pp laplata in 20646 Tagouri mil youhia M. 1165 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **APR 16**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 9, 2007 Leo David Korkia , Sr. 11:15 p^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bayside Care Center Lexington Park St. Mary 8. Date of Birth (Month, Day, Yea March 30, 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign), 1935 Minnesota Days Hours 72 476-36-7578 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Charles Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7012 Detroiter Place 20616 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian 11. Marital Status Black, White, etc. 2□ No 1953-1 MYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 1965 Specify: Specify: 3 ➡Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineering Tech. U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Korkia Elmer Hilda Heiniemi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Korkia, Jr. Son 6952 Skyline Place, Bryans Road, Md. 20616 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) / 17, April 1 Maryland Veterans Cemetery 2007 Cheltenham, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Road, Indian Head, Md. ter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease shock, or heart failure. ease, or complications that caused the death. re. List only one cause on each line. Approximate Interval Between Onset and Doath Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 2008/200 ft Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 4□Pregnant at time of death Month Dav Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a, Was an

Physician /Medical Examiner Examiner

Physician

Examiner

Funeral

Director

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r than "natural", or items 23a or the Medical Examiner must be

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Department of Health a Important: If item 27 is any Injury or other trau

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Division or Vital Records,

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Completed

physician and s the burial-tran attending p ed by the a signed b has been page 2 certificate

Physician/Medical

Completed by

Be

Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

> autopsy performed? 1□ Yes 2 🖪 No

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)										
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4™ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)									
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work? 1 Yes 2 No									
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)									

🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifiei Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and nanner stated. (Check only one) 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year)

ause of death (Item 28a) (Type, Print) 30. Name and add s of person who complete

James P. Jarboe. 4035 Three Notch Road, Hollywood, Md. 31. Date filed (Month, Day, Year) **APR 1 6** 200

State Registrar

State Registrar

31. Date filed (Month, Day,

Year)

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32. Registrar's Signature

		-	For State Registrar	State of Marylan	•	artment of F			ene g. No2007 13674						
7	Physicia	an	1. Decedent's Name (First, Middle, Last)		a second			2. Date of Deati	DayYear						
	/Medic	al	4a. Facility Name (If not institution, give s	Sebastian	Franci		3 r Location of Deat	topul 11	4c. County of Death						
	Examin	er	3710 Clarito	n Drive		MITCH	4 4	le	Prince George's						
1 m	Funeral		5. Social Security Number 6. Sex 577-60-0811	7. Age (In yrs. 97	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		of Birth 9. Birthplace (State or Foreign Country) 18, 1910 Washington, DC						
- 1	Director		Usual Residence of Decedent					Uaii 10,							
	within 72 hours after death with the Maryland ene. Than "natural", or Itame 23e or 28e-f show he Medical Examination the molified at	'n	10a. State 10b. County		y, Town or Lo		tchellvi.	110	10d. Inside City Limits 1 XYes 2 No						
	r 28a-f	Director	Maryland Prince Ge 10e. Street and Number	eorge s		10f. Zip Code	cherivi		Og. Citizen of What Country?						
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	er dea Itame	Funeral	11. Marital Clares	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2X No	.S. 13.	Was Decedent of F f Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.						
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural," or Itame 23a or 28a-1 ahow Important: if Item 27 is marked other than "natural," or Itame 23a or 28a-1 ahow Important: if Item 27 is marked or 28a-1 ahow Important in Item 23a or 28a-1 ahow Important in Item 23a or 28a-1 ahow Item 25a	by	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2KΩNo	Specify:		Specify: White						
215-0036	72 ho	leted	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wa	rking	16b. Kind of Business/Industry						
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Maryland	od 2 st Ith and 27 le n traun		19a. Informant's Name/Relationship (Type Patricia Geiger (I						arrollton, MD 20784						
ore,	as 1 ar of Hea Item :		20a. Method of Disposition		 Place of Dispo semetery, crer	sition (Name of matory or other pla	ce)	Date	20c. Location - City or Town, State						
Baltimore,	Page ment c		1 ∑Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Ga		Heaven Ce			Silver Spring, MD						
Ball	Depart Import Import any in		21. Signature of Funeral Service Lifenson 22. Name and Address of FacilityRendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706												
× 25	x 2-47		23a. Part1. Enter the disease, or compli	cations that caused the deat	h. Do not ent	er the mode of dyl	ng, such as cardia	c or respiratory arre	est, Approximate						
	Physician	0	shock, or heart failure. List only on Immediate Cause (Final disease or condition	Atlerosc	lerot	7c Ca	rdiovas	cule	Heart Wsecse						
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Box (death certifica e attending ph id for use as th	an/M	23b. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	v		23d. Date of delivery						
O. B		by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of c 9☐ Unknown		Other (specify)			Month Day Year						
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ecc	law re has be	Completed						24a. Was a autops	y prior to completion of cause of						
alB	(0 14							perform	No 1 Yes 2 No						
ΖÏ	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Ot	ner	Home 5 Reside	e) ence 6 Other (Specify)						
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	To the Hospital or Attent within 24 hours after deatl To the Funeral Director:	edical C							ause(s) and manner as stated. ate and place, and due to the cause(s)						
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	114		Laborer /	man do		40	055-90	+///	Grul 13, 2001						
	Je e		30. Name and address of person who co	mpleted cause of death (Item	m 23a) (Type,	Print)	Noe C	Hoverly	MARJANA						
Little of the second	Sta	ate rar	31 Date filed (Month Day Year)	32. Registrar's Sign	ature			0	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician ZZ10 M 04 asset 07 Kobert /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number **Examiner** Wickmie egional Medica Center 15 bury Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**™**M 2□ F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County ns 23a or 28a-f shov must be notified at 1 Yes 2 □ No Accomac Director nincoteaque 10g. Citizen of What Country? 10e. Street and Number Moad items 23a Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 ☐ Yes 2'M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shoreman Dundalk Marine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ ominic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Chincotcague UA 33
Date 20c. Logation City or Town, State Audrey 93336 asseth 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4/13/07 Exmore, VA 4 ☐ Donation 5 ☐ Other (Specify) Occobannock Crematory! hincotcaque, VA 23336 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Solver Funcial Home, Inc. 6327 Church St Imanda Botto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma 060 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in Jeath.) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe this certificate 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Medical Certification: To Be examiner? Hospital: 1 4 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2[No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. after death 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours a 1 🛨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and ti 4/12/07 s of person who completed cause of death (Item 23a) (Type, Print) m.1. NOHN 151061

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

APR 13

32. Registrar's Signature

And !

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Funeral Director		5. Social Security Number 213-38-4229 6. Sex 1 M 2 F 7. A	ge (<i>In yrs. last birthday</i>) 92 Yrs.	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept 28	9. Birtl S, 1914	nplace (State or Foreign untry) New Jersey						
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900	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced 12. Was Decedent Armed Forces If Yes, Give Year or Dates:	l No	Vas Decedent of Hisp f Yes, specify Cuban, I □ Yes 21X\(\overline{A}\)No	panic Origin? (Spe , Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:							
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W.	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Cause (Final disease or condition resulting in death) Due to (or as I consequence of):												
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_ta	sician: The certificate ha rector, page	BeC	25. Was case referred to medical examiner?			26. Place of Death			2010						
5	Physia this o	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpat			4 LI Nursing Hor		nce 6 Other (Spec	cify)						
O	ding l h. After funer	tion:	27. Mannor of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Inj (Month, Di	ay Year) 28b. Time of Injury	Work?	es 2∐No	28a. Describe how	w injury occurred							
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Certification:	2 ☐ Accident	njury - At home, farm, stre etc. <i>(Specify)</i>			28f. Location (Str. City or Town,	(Street and Number or Rural Route Number, own, State)							
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the bes 2 Medical Examiner: On the basis and manner s	of examination and/or inv	occurred at the time vestigation, in my opin	e, date and place, a nion, death occurre	and due to the ca ed at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)						
	To th withir Comp	Me	29b. Signature and little of certifier		29c. License r	number	29	d. Date signed (Monti	n, Day, Year)						
	5		Stan Par	ZKUPIE P	HYSICIAN	J 63	168	4 9	07						
			30. Na		Print)	cal Cont	or Drive	e Rockville	MD 20850						
	Sta	te		trar's Signature	Jaor Heul	.car cent	ET DITAG	LOCKVILLE	, FID 20030						
	Registr	ar	APR 1 3 2007	15 AD	345										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day/o Month Year **Physician** Milzman 0545 M 2007 ton /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Mosnita Baltmore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth December 1923 **Funeral** Days Hours Months 476-16-7529 1 □ M 2**X** F 83 **Yrs** Director MN Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 □ No r than "natural", or items 23a or 28a-f st the Medical Examiner must be notified MD Montgomery Potomac Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 United States 11631 Deborah Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 27 is marked any injury or also. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No Completed by White 3 Widowed 4 Divorced ear or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Salper Reuben Bureloff ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11631 Deborah Drive Potomac MD 20854 Frank O. Milzman - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Judean Memorial
Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/13/07 Olney, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityDanzansky-Goldberg Memorial Chape s 1170 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Syndrome 12 days Postcardistomy /Medical Due to (or as a consequence of): Examiner 12 days Replacement prost Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examine Stenosis year Aurtic the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hyperlipidemia autopsy performed? To the Hospital or Attending Physician: completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 April 10, 2007 MD

State Registrar NORTH WOLFE

gistrar's Signature

STREET

BALTIMURE

MARYLAND

21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

600

FITTON

31. Date filed (Montt

			1 - State Registrar			,		tificate d			Mental Hy	Reg. No				
ı	Physici		Decedent's Name (Fi Art1)		st) Markowitz						2. Date of De Month April	Da	•	Year	3. Time o	of Death
1	/Medic Examin		4a. Fecility Name (If not			or)		4b. City, Tov	m, or Loc	ation of Death			c. County (of Death	L	
	Exami		Holy Cros	s Hospita	a 1			Sil	lver S	Spring			Monte	gomery	r	
	Funeral		5. Social Security Numb	per 6. S	ex 7. /	Age (In yrs. last bir	thday)	If Under 1 Y	ear If (Jnder 24 Hrs. ours Min.	8. Date of Bir (Month, Da	th Voar			ace (State	or Foreign
	Director		091-18-9503		X M 2□ F	82	Yrs.	Months	ays In	ours will.	December				Jersey	
	and *		Usual Residence of Dec 10a. State 10	b. County		10c. City, Tow	n or Lo	cation						11	Od. Inside C	City Limits
	daryli f e ho	5								,						s 2 No
	the 28a-	Director	Maryland 10e. Street and Number	Montgome	ery			Silver S				10g. Ci	Og. Citizen of What Country?			
	3a or		1703	Sanford	Road					0902			п	S.A.	•	
	deat	Funeral	11. Marital Status		12. Was Deceder		13.	Was Decedent f Yes, specify (of Hispan	nic Origin? (St	pecify Yes or No)-	14. Race	- Americ		
98	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f ehow the Mudical Examiner must be notified at		1 Never Married		1 X Yes 2 [□No		1 ☐ Yes 2 🖾		exican, ruent	riloan, etc.)		Specify:	, White, e	elC.	
8	urai',	d by	3 Widowed 4		Year or Dates	1944-1945								Cau	ıcasian	ı
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77	iene.	E	Elementary/Secondar	ry (0-12)	College (1-4o	r 5+)		vil Engir				Fe	deral	Gover	nment	
Baltimore, Maryland 21215-0036	other	Bec	17. Father's Name (First	t, Middle, Last)					T .	Mother's Nam	e (First, Middle				Imene	
lar	uld be Aenta rked tic ev	To B		Moses Ma	ırkowitz				ļ	Mary	Cohen					
ar	2 sho and P		19a. Informant's Name/	/Relationship (Type, Print)	19b	Mailir	g Address (St	reet and f	Number or Rui	ral Route Numb	er, City	or Town, 5	State, Zip	Code)	
≥,	and sealth m 27		Ingeborg Ingebord		- Wife						Spring, N					
ore	ges 1 t of H if ite		20a. Method of Disposit 1 🖾 Burial 2 ☐ Cr		Removal from Star	remeter	Dispo y, crer	sition (Name of natory or other	f place)	į	Date	20c. L	ocation - (City or To	wn, State	
Ë	tant:		4 ☐ Donation 5 ☐	Other (Specify	v)		4	orial Ga			/2007	01	ney, M	aryla	nd	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "natural; or iteme 23e or 28a-f ehow eny injury or other traumatic event, the Medical Examinat must be notified at one.		21. Signature of Fundara	ar Service Licer	1586		l t		aldi	Funeral	Home, Indenue, Sil		Spring	, Mar	yland	20904
I			23a, Part1. Enter the di shock, or heart fai	isease, or compilure. List only	plications that caus	ed the death. Do r									Approxima Interval Be	ite
	Physician		Immediate Cause (Fina disease or condition	al	Lin	ngual Cellu	liti	.s							Onset and	
	/Medical Examiner		resulting in death)		Due to (or a	as a consequence	of):		-							
	LAdminer	-	Sequentially list condition	ons,	0.	eumonia	40								2 wee	ks
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injur	g 4					S Tax						0	h.T
	al-tra	Xar	that initiated events resulting in death) Last C. Anemia & Thrombocytopenia & Leukopenia Due to (or as a consequence of):										-	2 mon	tns	
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	tifical ng phy as th				1975 A 1975 A 1975 A 1975 A 1975 A 1975 A 1975 A 1975 A 1975 A 1975 A 1975 A 1975 A 1975 A 1975 A 1975 A 1975 A								(Personal de		150	
O. Box	The law requires that the death certaine hes been signed by the attendinage 2 should be detached for use	by Physician/M	IF FEMALE: 23b. Was decedent pre- in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	iths?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregr 4 ☐ Pregnant at time of death 5 ☐ Other (special)					Ectopic pregnancy					ry Day	Year
S,	s that ned b a deta	y Pt	Part II. Other significan	t conditions o	ontributing to death	but not resulting in	the ur	derlying cause	given in	Part I.	23e. Did t	obacco	use contri	bute to the	e cause of	death?
rds	w requires to been signer should be a										10	Yes 2	⊠ No	3 🗌 Proba	ably 4 🗆	Unknown
၀	aw re s bee 2 sho	Completed									24a. Was		24b. W	ere autop	sy findings	available
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>	hysic nis ce I direc	ToE	examiner?		Hospital: 1 🛮 Inpa	tient 2 ☐ ER/Ou	tpatien	3 □ DOA	Other: 4	☐ Nursing Ho	ome 5 Resi	dence	6 🗌 Othe	r (Specify)	
ouo	Attending Physician: r death. ector: After this certifice by the funeral director, p		27. Manner of Death 1 X Natural 5 2 ☐ Accident	☐ Pending investigation	28a. Date of In (Month, E		ime of njury		njury at Work? 1 [] Yes	2 No	28d. Describe	how inju	ry occurre	d		
Division of Vital Record	i or Atte efter dea Director	Certifications		Could not be determined	28e. Place of I	njury - At home, fa etc. (Specify)	rm, str	et, factory, off	ice		28f. Location (. City or To	Street ar	nd Numbe e)	r or Rural	Route Nur	nber,
	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificete hes completely filled in by the funeral director, page 2	Medical C	29a. Certifier 124 (Check only 2 one)	Certifying Ph Medical Exam	ysician: To the besinner: On the basis and manner:	of examination and	, death	occurred at threstigation, in r	e time, da	ate and place, n, death occur	and due to the red at the time,	cause(s date an	and man d place, a	ner as stand due to	ated. the cause(s)
	To th withir To th comp	M	29b. Signature and title		4			29c. Lic	ense nun	nber		29d. Da	te signed	(Month, L	Day, Year)	
	12		Peter	1 S.T.	3 WK, M	D,			D001	5060		Apr	il 11,	2007		
			30. Name and address of						-							
					., 10829 Ge	trada Cianatura			, Silv	ver Spri	ng, Maryl	and 2	20902			
	Sta Registr		31. Date filed (Month, D	R 1 3 2	007 32. Ra gis	strar's Signature	A	and I								

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

with the Maryland

death

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed Hospital or Attending after death dompletely filled in by the within 24 hours a the 10

Registrar DHMH 17 Rev 1/2001

Je.

State

Medical

HANDRASEKHAR 31. Date filed (Month, Day, Year) APK 13 200/

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

in itselles

Kusepit-MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANDRASEKHAR KORAPATI 7600

29c. License number

MD52855

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5&12 State of Manyland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** april 8:34 PM Ronald R. McCulloh 7007 15 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Ye Dec. 19, 9. Birthplace (State or Foreign Country)
PA 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Min 1949 57 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County an "natural", or items 23a or 28a-f show Medi al Examiner must be notified at Yes 2 No Mercersburg PA Franklin Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 17236 249 North Main Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S.
Armed Forces?
1 XXes 2 1970-11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No White Specify þ 1971 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglene Important: If item 27 Is marked other tha any Injury or other traumatic event, the LA Once. 曹 trucking co. driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Smith Roy McCulloh ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1527 North Chester Road, Hixson TN 37343 daughter Kelly I. Nelson 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Cumberland valley 4/17/2007 Waynesboro, PA 17268 1 ☐ Burial 2 X Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematorium 22. Name and Address of Facility Miller-Bowersox Funeral Home 521 S. Washington Street Greencastle, PA 17225 21. Signature of Funeral Service Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Unset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Duy to (or as a consequence of) Examiner R.C OW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Joseph of Hyur) that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part Ji: Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. <u>Ş</u> 1 Yes 2□ No 3 Probably 4 Unknown cate has been sit Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate has autopsy perform 1 Yes 2 100 25. Was case referred to examiner? funeral director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 N 1 Inpatient 1 Yes 2 ☐ ER/Outpatient 3□ DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manna Teath 28a. Date of Injury 28c. Injury at Work? e Hospital or Attending Post hours after death.
e Funeral Director; After the letely filled in by the funera After Injury (Month, Day Year) 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the To the within ? 29b. Signature and title 31. Date filed (Month State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

DHMH 17 Rev 1/2001

ORIGINAL

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	•	For State Registrar	State of N		tificate of Death	Rag	2007	13682
Physici	an	1. Decedent's Name (First, Middle	, Last)	Mil	ES	2. Date of Death Month	Day Year	3. Time of Death
/Media	al	- RANCES 4a. Facility Name (If not institution	T X.	1	4b. City, Town, or Location of D	Apr: I	4c. County of Death	9.30 1.
Examir	er			ŽD	Disa k	nne		51801
Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birth	9. Birthp	lace (State or Foreign
Director		212-16-7774	1 □ M 2 🕱 F	90 Yrs.	Months Days Hours	04-23-	1916 [Phil	adelphia, PA
land		Usual Residence of Decedent 10a. State 10b. County		10c City Town or Lo	cation		1	0d. Inside City Limits
Mary a-f sh	ţoţ	MD So	om or set	Frince	ss Anne			1 ☐ Yes 2 XNo
Deficiency in the property of the control of the many and permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: if item 27 is marked other than *natural; or items 23a or 28a-f show important: if item 27 is marked other than *natural; or items 23a or 28a-f show appropriately or items of the marked	Funeral Director	10e. Street and Number	1	DI	10f. Zip Code 2185		. Citizen of What Cour	ntry?
death v	erai	32188 PERRY	12. Was Deceder	nt Ever in U.S. 13.	Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, P		14. Race - Americ	
after o	/ Fun	1 Never Married 2 Marri	Armed Forces 1 Yes 2 2 If Yes, Give	QNo I	f Yes, specify Cuban, Mexican, P I □ Yes 2 ∑X No <i>Specify:</i>	ruerto Hican, etc.)	Black, White,	lack
hours fural;	ed by	3 ►Widowed 4 □ Divorced 15. Decedent	Year or Dates	:	dent's Usual Occupation	16	b. Kind of Business/In	dustry
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Manual Ma	Completed	Elementary/Secondary (0-12)		, , , ,	Laborer		Housew:	te
d be fill notal H	Be	Dennis Col	Last) EIN			Name (First, Middle, Ma		
should nd Mer marke	ဥ	19a. Informant's Name/Relations	nip ype, Print)	19b. Mailir	ng Address (Street and Number of			Code)
and 2 and 2 ealth a n 27 is		William M. /	diles- S	on 3211	3 Perry Haw		incess Ann	
of He roth		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation	3 □Removal from Stat	8	sition (Name of natory or other place)		c. Location - City or To	
t. Pages rtment of rtant: ff it		`4 □Donation 5 □ Other (S)	pecify)	SI. Mark		4-17-8007		MD
Denmit. Depart Import any inj		21. Signature of Funeral Service	L. Ward		Name and Address of Facility		Anne, Mi	
		23a. Fart1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	ed the death. Do not ent line.	er the mode of dying, such as ca	rdiac or respiratory arres	ι,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	-a ARTH	EROSCLEN	2071C VASC	ular Di	SEASE	Onset and Death
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ath cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
w requires that the death certificate be executed wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnant 9☐Unknown		Other (specify)			
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VIII /sicial	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital	atient 2 ER/Outpatier		ing Home 5 Residen	ce 6 □Other (Speci	(v)
ng Phy rer this	n: T	27. Manner of Death 1 ☑ Matural 5 ☐ Pendin	28a. Date of Ir			28d. Describe how		
SIOII tending leath. tor: Afte the fune	catic	2 Accident investig	gation		M 1 □ Yes 2 □ No		et and Number or Run	al Pouto Number
after of Direct of in by	Certification;	4 Homicide determ	ined 200. Flace of	Injury - At home, farm, sti etc. (Specify)	eet, factory, office	City or Town,		ar noble (vuiliber,
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as it	Medical C	29a. Certifier 1 Cartifyin (Check only one) 1 Medical	ng Physician: To the be Examiner: On the basis and manner	of examination and/or in	h occurred at the time, date and p vestigation, in my opinion, death	place, and due to the cau occurred at the time, date	se(s) and manner as s e and place, and due t	stated. o the cause(s)
To th within To th compl	Me	29b. Signature and title of certifie		<i>f</i>	29c. License number	290	d. Date signed (Month,	Day, Year)
		10	- Com	cl M.D.	15075	9 1	4PRIL, 16	2007
6 EB		30. Name and address of person	who completed cause of	of death (Item 23a) (Type,	PINEBLUFF RD	SALIS	BURY N	10 2180/
Sta	ate	31. Date filed (Month, Day, Year)		rar's Signature	1 .			
Regist		TAK I	7 2007	THESER ST.	Closus 1			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month April 2007 **Physician** FRANCES MATTHEWS M_ 13, 8:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** McCready Memorial Hospital Crisfield Somerset Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 4, 1925 7. Age (In yrs. last birthday) **Funeral** Days 215-20-0911 Maryland 1 □ M 2 ☑ F 82 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "natural", or iteme 23s or 28s-1 show or other traumatic event, the Madical Examinar matal be notified at Maryland Somerset Marion Station 1 Yes 2 No Funeral Director 10f Zin Code 10e. Street and Number 10g. Citizen of What Country? 5769 Charles Cannon Road 21838 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify: Be Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 90 Pages 1 and 2 shouid be ment of Heelth and Menta tant: if item 27 is marked Cleveland Somers Esther Anderson ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Ann Rettiq (Sister) 26925 Holly Avenue - Crisfield, MD 20b. Place of Disposition (Name of cometery, crematory or other place)
St. Paul's Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: if any injury or once. 4/17/07 Marion Station, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Emeral Service License 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw, H 306 W. Main St. - Cristield, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarct 2 Hours /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Years Sequentially list conditions, if any landing to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed Atherosclerosis Years that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the attending physicien Hypertension Years Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 4☐Pregnant at time of death 5 Other (specify) detached 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed page 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Watural 5 Pending 1 □ Yes 2 □ No death. investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Sign 29d. Date signed (Month, Day, Year) 29c. License number D0042083 April 13, 2007 se of death (Item 23a) (Type, Print) nd address of pe Wheeler-Gunta McCready Memorial Hosp. - 201 Hall Highway - Crisfield, MD EB Α. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 1 A. Speck 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierfe 1 - For State Registral Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1 Decedent's Name (First, Middle, Last) MAIN **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If hot institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 M 2 F 99 02/08/1908 Texas Director 485-05-2842 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b County or 28e-f show the Medical Evan in or must be notified at 1XXYes 2 ☐ No Directo Maryland Prince Georges Rowie 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number or itams 23a 15202 Plane Tree Court 20721 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

ant; If itam 27 is marked other than "natural", or Itams 23.

Lry or other traumatic event, the Medical Event is entirent. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify White 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Peoples Drug Elementary/Secondary (0-12) College (1-4or 5+) Store Cosmetologist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carrie Antoinette Kahn Gustave Adolph Reinert ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15202 Plane Tree Court Bowie, MD 20721 Keith Dawson/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Resurrection Cemetery 04/10/2007 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Functa 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or als a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year ö in the past 12 months? 5 Other (specify) ☐ Yes 2 No Division of Vital Records, P.O. the 9 Unknown detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Compieted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform 1 ☐ Yes 2 ☐ No 2 0 No 1 ☐ Yes Hospital or Attanding Physician: 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No this 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 5 Pending investigation 1 Alatural 1 🗌 Yes 2 🗌 No death. 2 Accident after death Diractor: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29h Signature and title of certifier m b completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) gistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 1 2 2007

			1 - For Stete Registrer	State of Man		epartme Certifica			nd Me		giene	07	13685
	Physici	an	1. Decedent's Name (First, Middle, Last)						2	2. Date of De	ath Day	Year	3. Time of Death
	/Medic		John Dewey McGlo							APRIL	10	2007	17.18 PM
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	yland		10a. State 10b. County	10	Oc. City, Town o	r Location						1	0d. Inside City Limits
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36	or it		1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give		1 ☐ Yes		Specify:			Specif		
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			Decedent's Name (First, Middle,	Last)				0, 50		2. Date of D			3. Time of Death	
	Physic /Medi		Richard Wilb	ur MacKay	7					Month April	9	ay Year 2007	6:30PM A	
1	Exami		4a. Facility Name (If not institution, g	give street and number)			4b. City, T	own, or Lo	cation of Death	11-1-1	1	c. County of Deat		
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	yland		Usual Residence of Decedent 10a. State 10b. County	·	10c. City,	Town or Lo	cation			····			10d. Inside City Limit	
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	dea dea	ner	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decede	ent of Hispa	nic Origin? (Sp Mexican, Puerto	ecify Yes or N	lo-	14. Race - Ame Black, White		
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene. If flem 27 is marked other than "natural", or items 23s or 28s-1 show or other treumatic event, the Madical Exam, an minist or actiliad at	Completed by Funeral Director	1 □ Never Married 2 🔀 Married 3 □ Widowed 4 □ Divorced		No	1	1 ☐ Yes 2		pecify:	riouri, dio.j			hite	
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Maryland	2 shc and ie mu		19a, Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address (Street and	Number or Rura	al Route Numi	ber, City	or Town, State, Z	ip Code)	
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Baltimore,	Pa Pa		20a. Method of Disposition 1		cem	etery, crer	sition (Name natory or oth viden	ner place)	m. 4/13	/2007		Location - City or 1		
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			23a. Part1. Enter the disease, or co	emplications that caused	d the death.	Do not ent	er the mode	of dying, si	ry's Av	e La l or respiratory	Lat arrest,	a,MD 20	Approximate Interval Between	
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.O. Box (that the death certificate ed by the attending phys detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic pred Other (spec					23d. Date of deli Month	very Day Year	
<u>a</u>	res that igned b be deta	ρ	Part II. Other significant conditions	contributing to death b	ut not resulti	ng in the ur	nderlying cau	use given in	Part I.				the cause of death?	
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Division	or after Direction by	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At home c. (Specify)	e, farm, str	eet, factory,	office		281. Location City or To	(Street a	and Number or Ru te)	ral Route Number,	
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State Registrar

31. Date liled (Month, Day Year) APR 1 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dave Cristo, M.D. 8901 Wisconsin Ave. Bethesda, MD 20889

29b. Signature and title of certifier

29c. License number 711, 1015

036-105 699

29d. Date signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Walter Nicholson April 2007 1:20 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Months Days Hours Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Min. 0990671932 577 42 9101 18 M 2 □ F 74 Washington, DC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits notified Prince Georges TYes 2 No Oxon Hill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 20745 5 Panorama Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Examiner Black, White, etc. 1**★** Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify Specify: Black 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) $5\pm$ Lawyer Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Nicholson, Sr. Allidees Ham ပ item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Nicholson 5811 Garden Dr., Clinton, MD 20735 daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of H
Important: If ite
any injury or of **₩** Burial 2 □ Cremation 3 □ Removal from State 04/20/07 Triangle, VIrginia 4 ☐ Donation 5 ☐ Other (Specify) Quantico National Signature of Juneral Service 22. Name and Address of Facility John T. Rhines Funeral Home, LLC 20017 3015 12th Street, NE Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final Physician Sepsis resulting in death) /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Dehydration Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ♣ No 24a. Was an autopsy performed? Yes 213No page 2 or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2€No 1 📑 Inpatient Certification: To 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) uneral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital I 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MA D0063343 April 9, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Irina Rubar 1500 Forest Glen Road, Silver Spring, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:52 a M JAMES CLARENCE NALLEY April 9, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Annapolis** Anne Arundel Medical Center Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days 1**X**M 2□ F Hours Min. 579-34-8798 78 08-09-1928 Washington, DC **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 144 Washington Road 21037 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify. þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Higear Warehouse 12 should be filed w h and Mental Hygiei Is marked other ti 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Henry Nalley Mary Leona Notey ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Dorothy J. Moore - Niece 4964 Elm Street, Shadyside, Maryland 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation \$ □ Other (Specify) 04/14/2007 Olivet Cemetery Washington, DC 21. Signatur of Fur eral Servi, e Lorns 22. Name and Address of Facility 4739 Baltimore Ave. ay Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C use (Final disease or c ndition resulting in eath) **Physician** /Medical Due to (or as a consequence of) **Examiner** Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 4 Unknown 1 Tes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours a er deah.

The Funeral Director Apletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital completely filled to the cause(s) and manner as stated. 29a. Certifier ledical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the within 2 29c. License number 29d. Date signed (Month, Day, Year) 9b. Signature and titl D00058297

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

DUNE 32. Registrar's Signature

Anachrundel Medical Cente. Annapolis MO 21461

13690

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** MARY 2007 NESBITT APRIL 11 10:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BRADFORD OAKS NURSING HOME CLINTON PRINCE GEORGE'S 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex Birthplace (State or Foreign Country) Days Hours 1□M 2□F Yrs. Director 578-34-9510 4/1/1929 SOUTH CAROLINA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Medical Examiner must be notified at Director ty Yes 2 No MD PRINCE GEORGE'S FT. WASHINGTON 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ 4505 LUJEAN LANE 238 20744 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itar any injury or othar traumatic avant, the Medical Examinat once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th HOUSE WIFE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH CARTER ALLIE STEVENS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR NESBITT/HUSBAND 4505 LUJEAN LANE FT. WASHINGTON, MARYLAND 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 □Donation 5 □ Other (Specify) ARLINGTON NATIONAL 4/26/2007 ARLINGTON, VIRGINIA 21. Signature of Funeral Sorvice Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Fnysician DANCREATIC CANCER disease or condition resulting in death) /Medical Due for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or frighty that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of deliver 3 ☐ Ectopic pregnancy in the past 12 months? for Year Month Day 4□Pregnant at time of death 5 Other (specify) P.O. ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the Hos within 24 ho To the Fun completely 1 (Check only one) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) Fut washington, may/md TITANNER MY William Livingston Korl 1170) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29c. License number 29d. Describe now injury occurred 29d. Describe now injury o	2	cien: ertifica ector,	Ф								of Death						
30. Name and address-of pason who completed cause of death (Item 23a) (Type, Print) 3001 Hosp De Chevery MO 20785 — Terrin Matin: State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	5	Physi this o			i Dalir				JUA	4 🔲 🛚 🕦						fy)	
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30. Name and address-of pason who completed cause of death (Item 23a) (Type, Print) 3001 Hosp De Chevery MO 20785 — Terrin Matin: State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		ne Hospit n 24 hour ne Funer letely fills		(Check only 2 Medical Exam	tiner: On the ba	sis of examina	owledge, deat ation and/or in	th occurrenvestigation	d at the tir on, in my o	ne, date an pinion, dea	nd place, a oth occurre	and due to the o ed at the time, o	cause(s) date and	and mar I place, a	nner as s	stated. to the cause(s)	
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Registrar AMR 13 2007	p			V	32. Re	egistrar's Sign		, ,	100			10,1	1471	~11	y 1 '		

			1 - For State Registrar		State of	Maryl	and / Depa <i>Ce</i>	artmen rtificat				lental Hy	gien) 7	13692
	*	į.	Decedent's Name (First, Middle	, Last)								2. Date of D	eath		.,	3. Time of Death
	Physici		REGENA	v.	Р	EARSO	N					Month APRIL		200	Year)7	1:00 P M
	/Medic Examir		4a. Facility Name (If not institution					4b. City,	Town, or	Location	of Death	11111111			of Death	1.00 1
	Exami	ICI	LAUREL REGIO	-					LAUI	RET.				PRTN	CE GE	EORGE'S
à.	Funeral		5. Social Security Number	6. Sex			rs. last birthday)		1 Year	If Under		8. Date of B	irth			place (State or Foreign
	Director		578-62-3046	1 🗆 1	1 2 ∑ F	62	Yrs.	Months	Days	Hours	Min.	(Month, D	2 19	945	WASH	INGTON, DC
	ס		Usuat Residence of Decedent					11								
	ahow		10a. State 10b. County			10c.	City, Town or Lo	ocation							1	10d. Inside City Limits
	Ma F	Director	MD PRIN	CE G	EORGE '	S	LANDO	VER								1 X Yes 2 □ No
	n the	lre	10e. Street and Number					10f. Zip	Code				10g. C	itizen of	What Cour	ntry?
	death with the Maryland ma 23a or 28a-f ahow Littus Le nullied at		7511 GREENLEAF	ROA	D					2078	35			U	S.A.	
	n 72 hours after death with the Maryla "natural", or itema 23a or 28a-1 ahov softal Entartinat mant be nutilised at	Funeral	11. Marital Status	12	. Was Dece Amed For		n U.S. 13.	Was Deced	dent of Hi	ispanic Or	igin? (Sp	ecify Yes or N Rican, etc.)	0-		ce - Americk, White,	can Indian,
ō	within 72 hours after ene. then "natural", or ite		1 Never Married 2 Marr		1 ☐ Yes If Yes, Giv	2 X No		1 Yes		Specify:		, , , , , , , , , , , , , , , , , , , ,		Specif		ACK
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and	0 = >	Be	17. Father's Name (First, Middle,								ers Nam MARY	e (First, Middle WILLI		n Sumai	ne)	
Ž	Men Merke Marke	은	JULIUS BENNE													
0	2 sh and ie m		19a. Informant's Name/Relations			7D		-				al Route Numi				
< ~`	and ealth m 27		JAYNELL C MUNG	KU/ D.	AUGHII					.r 511		LANDOV				
5	of H if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Rer	noval from 5	1	 Place of Disponentery, cre 			e)	,	Date	20c. I	Location	- City or To	own, State
	Paginent:		4 □ Donation 5 □ Other (S	pecify)		I	HARMONY	CEMET	ERY	4		/2007				RYLAND
Saltimor	permit. Pages 1 and 2 should be Department of Health and Menta important: if Item 27 is marked any injury or other traumatic e <u>9068</u> .		21. Signature of Funeral Service	Licens	1	0	2	2. Name an								RAL HOME
_	20 E 2 9		K. D. N	-	ral	V		7474	LAN	DOVER	ROA	D LAND	OVER	,MAR	YLANI	20785
			23a. Part1. Enter the disease, or shock, or heart failure. List	complica only one	tions that cause on e	aused the d ach line.	leath. Do not en	ter the mod	e of dyin	g, such as	cardiac	or respiratory	arrest,			Approximate Interval Between
	Physician	9 1	Immediate Cause (Final disease or condition ACUTE MYOCARDIAL INFARCTION											119	Onset and Death	
	/Medical		resulting in death)	€ a	Due to (or as a con	sequence of):					· · · · · · · · · · · · · · · · · · ·		******		
	Examiner		Sequentially list conditions	b.			ARY ARTE	RY DI	SEAS	E						
L	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	Due to (or as a con	sequence of):									
	nd nd trans	Examine	that initiated events	С.			ETES MEL	LITUS								
<u>5</u>	cate be executed physician and the burial-transit	E	resulting in death) Last		Due to (or as a con	sequence of):									
00/0	ate br	dlcal		d.												
Ď	certifica nding pt use as t	Med	tF FEMALE:					-	 							
Š	w requires that the death certific been signed by the attending p should be detached for use as:	Physician/Me	23b. Was decedent pregnant	230	If yes, out 1 ☐ Live b	come of pre inth 2 F		⊒Ectopic p	egnancy						ite of deliver	ery Day Year
	e death he atten ed for u	slcl	in the past 12 months? 1 Yes 2 No		4☐Pregn 9☐Unkno	ant at time	of death 5	Other (sp	ecify)					141	21111	Day Yeas
5	requires that the een signed by th hould be detache	Phy	9 Unknown									1				
n î	igned bed	b	Part II. Other significant condition	ns contr	ibuting to de	ath but not	resulting in the u	inderlying d	ause give	en in Part	l.					he cause of death?
	equir sen s ould	ted										1_	Yes 2	2 K I No	3 🗌 Prol	bably 4 Unknown
ပ်	law r as be 2 sh	ompleted										24a. Wa	s an	24b.	Were auto	opsy findings avaitable empletion of cause of
	The law ate has b page 2 s	Com										peri 1 ☐ Yes	opsy formed? 2 N	1	death?	
0	hysician: The law his certificate has b I director, page 2 s	Be	25. Was case referred to medical examiner?							26. Place	e of Deat	h (Check only	one)			
<u> </u>	Physician: r this certific ral director,	70	1 ☐ Yes 2 ☒ No	Ho	spital: 1 🗆 li	npatient 2	2X ER/Outpatie	nt 3 🗆 DC	Oth	er. 4 □ Ni	ursing Ho	me 5 Res	sidence	6 □Oti	ner (Specil	(y)
ō	Pg P tert	on:	27. Manner of Death 1 ☐Natural 5 ☐ Pendin	_	28a. Date of (Mont	of Injury h, Day Yea	z8b. Time o	of 2	8c. Injun Wor	/ at k?		28d. Describe	how inj	ury occu	red	
<u> </u>	Attending in death.	atlc	2 Accident investig	gation				М		Yes 2	No					
DIVISION	al or Attendir s after death. I Director: Af d in by the fur	Certificati	3 ☐ Suicide 6 ☐ Could in determ		28e. Place	of Injury - A	At home, farm, st	reet, factory	, office			28f. Location City or To			ber or Rura	al Route Number,
5	spital or Atten ours after deal neral Director: filled in by the	Cer				· · · · · · · · · · · · · · · · · · ·								,		
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by						knowledge, deal									
	To the Hos within 24 h To the Fur completely	edical	one)		and manr	er stated.	mianori and/or ir				aut OCCUI	ou at the time				
	To the within 2. To the complet	Σ	29b. Signature and title of certifie				1	290	c. License	e number						Day, Year)
	00		D 1VI+	-)		te			D00	02312	25		AP	RIL	11, 2	2007
	45		30. Name and address of person	who com	pleted cays	e of death (Item 23a) (Type	Print)								
	(10)		MADHU MOHAN	M.D	. 6502	KENI	LWORTH	AVENU	E #	100 F	RIVER	DALE.	MARY	LANT	207	37
83	s Sta		31. Date filed (Month, Day, Year)		32. R	egistrar's S	ignature									
	Registi	rar	APR 13 2007	Haro:		1. S.	and I									

DHMH 17 Rev 1/2001

ORIGINAL

Division or Vital Records, P.O. Box 68760,

The Peter To the within 2

Date filed (Month, Day, Year) State Registrar

FARAH I FAR M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801

4.10.07

Georgia Are Snit 3-4 Silver SprigMD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Julia Reed - Reese 04 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Manyland - Shock Trauma Baltimore if Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** Months Days Hours Min. 1 □ M 🛣 F 84 Director 099-14-7207 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the <u>Medical Examiner must be notified</u> at Director FORT WASHINGTON MD PRINCE GEORGES the 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or: 20744 8137 MURRAY HILL DRIVE Funeral 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. à 3 XWidowed 4 ☐ Divorced Completed

2. Date of Death Day 05 55 AM 2007 4c. County of Death Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) BROOKLYN, NY 11-14-1922 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPR PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GEORGE CALCOTE LUCY COBBS

Be

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

DEBRA AKERS/NIECE 20a. Method of Disposition

1X Burial 2 ☐ Cremation

19a. Informant's Name/Relationship (Type. Print)

2729 WOOD HOLLOW PL, FT. WASHINGTON, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place)

4 □ Donation 5 □ Other (Specify) at re of Foneral Service Occurse

3 ☐Removal from State

04-17-2007 SUITLAND, MD CEDAR HILL CEMETERY 22. Name and AddreMARSHALL'S FUNERAL HOME OF MD, INC.

lea

4308 SUITLAND RD, SUITLAND, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

basal ganglia nemorriagi Due to (or as a con- quence

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔯 No

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

20c. Location - City or Town, State

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9☐Unknown

1 ☎ Inpatient

1 Tes 2 No 3 Probably 4 Munknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 1 □ Yes 2 □ No

28d. Describe how injury occurred

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

29b. Signature and title of certifier ND

AU4176435M16779

29d. Date signed (Month, Day, Year) 11/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Baltimore Street South 6 Veene Meenag 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

t of Health If Item 27 i or other tra

Department of Important: If II any injury or conce.

Physician

/Medical

Examiner

attending physician and for use as the burial-transit

been signed by the should be detached

page 2 s

funeral director,

certificate

After this

within 24 hours after death.

To the Funeral Director: Aft

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2

Exami

Physician/Medical

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Completed

Be

To

Certification:

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O.

Box 68760.

		, FOI	partment of Health and Mertificate of Death	lental Hygie	. 7 11111	13696
		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physic		Deborah Anne Reynolds		April 13	Day Year 3 . 2007	2:00 AM ^M
/Med Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		26739 Mt. Vernon Road	Princess Anne		Somerset	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthpl Coun	ace (State or Foreign try)
Director		221-28-7301 74 62		04/08/194		ware
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		11	Od. Inside City Limits
Manyl f sho	ō					1 Yes 2 □ No
the t	Director	MD Somerset Prince:	SS Anne 10f. Zip Code	10g.	Citizen of What Coun	try?
a with		26739 Mt. Vernon Road	21853		USA	
death ms 2:	Funeral		Was Decedent of Hispanic Origin? (Sport of Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America	
after after		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No	1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Black, White, e	etc.
-UUJO hours after death with the Maryland turel; or Items 23a or 28e-f show at Evenilier inust be notified at	l by	3 ☐ Widowed 4 Divorced If Yes, Give Year or Dates:	To Tes Zanto Specify.		Specify: Whi	te
1213-UU36 within 72 hours after death with the Marylan ane. than "naturel", or Items 23a or 28e-f show	Completed	(Specify only highest grade completed) (Gin	edent's Usual Occupation re kind of work done during most of work	ing 16b	o. Kind of Business/Inc	lustry
within 72 ene. than "nat	I du	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	CI	-414 C	.t. Direi -i
y bed to		12 2 COO	rdinator	First, Middle, Mai		t Division
and the f	Be	John O. Dickerson		ne Wright		
Ore, Maryland les 1 and 2 should be file of Health and Mental H, if Item 27 is marked oth	2		iling Address (Street and Number or Run	The same same	ity or Town, State, Zip	Code)
		1	39 Mt. Vernon Road,		-	
re, s 1 ar f Hea f Hea othe		20a. Method of Disposition 20b. Place of Dis	position (Name of lematory or other place)	Date 200	c. Location - City or To	wn, State
Pages nent of ant: If It		1 Burial 2 Cremation 3 Removal from State		7/2007 Mt	t. Vernon,	Maryland
Baltimore, permit. Pages 1 ar Department of Hea Importent: If Item any injury or othe		At Signature of Funeral Service Licensee	22. Name and Address of Facility			
n gomes	1	MARCA NEMPLANDA MODES	Hinman Funeral Home 1673 Somerset Ave.	. Princes	s Anne. MD	21853
-		3a. Part1. Enter the disease, or complication, that caused the death. Do not e shock, or heart failure. List only one car be on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
Physician	1/	Immediate Cause (Final disease or condition			1	Onset and Death
/Medical		resulting in death) a Due to (or as a consequence of):				
Examiner		Sequentially list conditions.				
ק ק	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
ecute and -trans	Examiner	Cause (Disease or injury that initiated events c				
OX 68 /6U, certificate be executed nding physicien and use as the burial-transit	calE	530 10 (01 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
68/ ificate g phys	70	d.			. 1	
BOX 68 eath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ry
death cert death cert e attendin	ciar	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
that the de led by the a	hys	9 ☐ Unknown				
ecords, P.O. law requires that the as been signed by th	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
COLD:				Yes	2 No 3 Prob	ably 4 □Unknown
ecords, law requires t as been signe	Completed			24a. Was an autopsy	24b. Were auto	osy findings available inpletion of cause of
The The ate h	E O			performed		
OT VITAL MEC Physician: The law this certificate has lared director, page 2 s	Be (25. Was case referred to medical examiner?		h (Check only one)		
OT V Physic rthis corral dire	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat			e 6 Other (Specify)
E gring	ion:	27. Manner of Death Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury 28b. Time Injury	Work?	28d. Describe how i	injury occurred	
Attending rideath.	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	M 1 Yes 2 No	28f Location /Stree	et and Number or Rura	I Route Number
Dir	Certification:	4 Homicide determined building, etc. (Specify)	sireet, factory, office	City or Town, S		710010 710111001,
urs urs erel		29a. Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place,	and due to the caus	se(s) and manner as st	ated.
DIVISIO To the Hospital or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the the	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
To th Within To th	Me	29b Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
			HU05619	2	4/13/20	27
		30. and addre of person who completed cause of death (Item 23a) (Typ	e, Print)	~ . ~	111	
20 EB	1 8	218 Newton ST S	ath occurred at the time, date and place, investigation, in my opinion, death occur 29c. License number Hoo 5615 e. Print)	2180	01	
4.	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	655			
Plegis	trar	APR 1 7 2007	Social .			

Andre Clifton Ste	1	For State egistrar	tate of Marylar		tment of Hi ificate of De		vientai Hy	_	eg. No. 200	17 13697
Physicia Medical Examir	n/	Decedent's Name (First, Mid		STEED				2. Date of Dea Month April 8, 20	Day Year	3. Time of Death 2303 hrs
)		4a. Facility Name (if not institut			1	city, Town, or Loc	ation of Death	710111 0, 20	4c. County of De	
Funeral	4	903 Newhall Street 5. Social Security Number	6. Sex 7	7. Age (In yrs. las		Ilver Spring Under 1 Year	f Under 24Hrs.	8. Date of Bir	Montgomer th(MM/DD/YYYY) 9.	<u> </u>
Director		215-94-4614		27			Hours Min.		Fo	reign Cou Wash. DC
any		Jsual Residence of Decedent 10a. State 10b. County	,	10c. City, T	own or Location					10d. Inside City Limits
Maryland 28a-f show any d at once.	5	MD Mor	tgomery		Germa					1XYes 2 No
Maryl	Director	Oe. Street and Number 21214 Wate	waxaaa C	in all	10	f. Zip Code	_	1	0g. Citizen of What C	
with the		21214 Wate		edent Ever in U.S		20876 cedent of Hispan	nic Origin? (Sp			merican Indian, Black,
death or item	Funeral	-	Married Armed For	2 No		specify Cuban, Mo		Rican, etc.)	White, etc	
rs after ural",	<u>a</u>	3 Widowed 4 D 15. Decedent's Education (Sp	OLDAIGS.	UNII	1 Yes	s 2 X No s		ork done	Specify: 16b. Kind of Busine	Black ess/Industry
72 hou n "nat	Completed	Elementary/Secondary (0-12	College (1-	4 or 5+)	•	of working life. DC		ed)		n Auto
0036 within giene her tha	d mo	17. Father's Name (First, Middl	l yı	c		Me ch ani		(First. Middle.	Group Maiden Surname)	
215- be filed ntal Hyg ked of	BeC	Tony C. E					M	2 2 2 2 2 2	+ Thomas	son
2 21 should be nd Mer is mar	리	19a. Informant's Name/Relation		/Mother	19b. Mailing Ad	dress (Street ar	nd Number or R	tural Route Nur	mber, City or Town, S	tate, Zip Code)
and 2 stealth a	-	Margaret I 20a. Method of Disposition			ace of Disposition	(Name of cemete		Date	20c. Location - City	ntown, MD y or Town, State
MOF6 Pages ent of F	ŀ	1 XBurial 2 Cremati 4 Ponation 5 Other	on 3 Removal fro \$pecify:* ↑	III State	ematory or other p		4/	14/07	German	ntown, MD
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Servi	e Licerisee	Hen ()						HOME, P.A.
Physician	7	23a. Part I. Enter the disease;	or complications that ca	aused the death.						Approximate Interval
/Medical		failure. List only one caus Immediate Cause (Final diseas	se on each line.							Between Onset and Death
Examiler		or condition resulting in death	Due to (or as a	consequence of)	:					
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	se c	consequence of)	:					
uted id iansit	ledical Examiner	(Disease or injury that initiated events resulting in death) Las		consequence of)						
68760, certificate be executed nding physician and use as the burial - transit	dica	UNPENDED	AMENDED							
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Box 68760, e death certificate by the attending physic ed for use as the bur	Physician//	past 12 months? 1 Yes 2 No 9 U	17 -	ant at time of dea	ath 5 Other	(Specify)				
cords, P.O. Bo. law requires that the deall has been signed by the att		Part II. Other significant con			sulting in the unde	rlying cause give	en in Part I.	- 1		e to the cause of death?
S, P.O.	ed by							1Ye		Probably 4 Unknown e autopsy findings available
ords aw requas beer 2 shoul	Completed							auto perfe	psy prior ormed? deat	r to completion of cause of th?
tal Rec		25. Was case referred to med	cal			26 Place of	Death (Check		2 No 1	Yes 2 No
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n of viding Ph. h After tl	-	27. Manner of Death	28a. Date (Month Apr 8, 2	of Injury Day,Year)	28b. Time of Injur 2255 hrs		at Work? s 2 ✓ No	28d. Describe Subject she	how injury occurred ot self	
Division of Vital Records, tall or attending Physician: The law requires after death. After this certificate has been she from the funeral director, page 2 should it by the funeral director, page 2 should it.	ertification:	2 Accident In 3 Suicide 6 C	vestigation 28e. Place		nme, farm, street, f	actory, office buil		or Town,	State)	or Rural Route Number, City
Hospi 24 hou Funer cely fil	ပ	29a. Certifier 1 Certifying	Physician: To the bes	residence st of my knowledg	ge, death occurred	at the time, date	and place, and	due to the cau	Street, Silver Spri	stated.
To the Hos within 24 h To the Fur completely	Medical		xaminer:On the basis of and manner s		nd/or investigation	29c. License r		at the time, date		(Month, Day, Year)
3	2	29b. Signature and title of cer	1	Del.	140	O.C.M.			April 9, 2007	
		30. Name and address of pers				11 Penn Stre	et Baltimo	re MD 212	01	
S	tate	Patricia Aronica-Po 31. Date filed (Month Pay, Ye	ab 2007 32.	ant Medical E egistrar's Signatu			.c., Daimino			
Regis		HLL/ T	0 2001	sever 1	1. P. J. J. J. J. J. J. J. J. J. J. J. J. J.					

James Linwood		1- For State	State	of Maryla	•	artment of rtificate of			Menta	i Hy		Reg. No	20	0.	7	13698
Physicia		Registrar 1. Decedent's Name (First,	Middle,Las	st)					•	2	. Date of De	ath			3. Time	of Death
Medical Exami		James Linwo	od St	nuler							Month April 3, 2	Day 2007	Year	İ	0029	hrs hrs
		4a. Facility Name (if not in: Washington Adve			umber)	4	b. City, Too Takom			Death			c. County of Montgom			
Funeral		5. Social Security Number	6. S	ex	7. Age (In yrs. I	last birthday)	If Under	_	If Under		8. Date of E	Birth (MM	I/DD/YYYY)	9. Birth	nplace (S	tate or
Director		579-56-8959	1 2	M 2 F		61 _{Yrs.}	Months	Days	Hours	Min.	Dec.	21,	1945	Cou	Nort	rolina
	ı	Usual Residence of Deced													<u>va</u>	LOTTIIA
any		10a. State 10b. C	ounty		10c. City	Town or Location	on									de City Limits
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Aaryland 28a-f show 1 at once.	Director	10e. Street and Number		3 30019		11001011	10f. Zip C	ode				10g. Ci	tizen of Wha	t Coun	try?	
ith the Maryland 23a or 28a-f sho notified at once	ä	8601 21st	Place	9			20	783			i		Ţ	USA		
with ns 23 be no	<u>ra</u>	11. Marital Status			cedent Ever in U						cify Yes or N	lo-	14. Race -		an India	n, Black,
Jeath r iter	Funeral	1 Never Married 2	Married	Armed F	orces?	If Ye	s, specify	Cuban, I	Mexican, F	uerto R	ican, etc.)		White,	etc.		
after all', o	by F	3 Widowed 4	_	If Yes, Give Ye	ar 1965 - 6	8 1	Yes 2	₹ No	specify:				Specify:B	lack	ς .	
ours	호[15. Decedent's Education	(Specify o			16a. Decedent	s Usual O					16b.	Kind of Busi	iness/Ir	ndustry	
6 72 h an "r	ete	Elementary/Secondary	0-12)	College (1-4 or 5+)						-/		***			
003 within er th	Completed	12				Syst	ems 1						Veri	zon		
21215-0036 uld be filed within 7 Mental Hygiene marked other than ic event, the Medica	Š	17. Father's Name (First, Marian Shule)		t)					s.Mothers stell		First, Middle	, Maidei	n Surname)			
112' Id be fental	Be	19a, Informant's Name/Re		Type Print \		19b. Mailing	Address					ımher (City or Town	State	Zin Cod	<u> </u>
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygene fant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	٩		•											Claro	p 000	,
and 2 and 2 ealth rem 2 traum	ŀ	Gloria D. 20a. Method of Disposition	Shule	er/Wife	20b.	8601 2 Place of Disposi	lst F tion (Name	of ceme	etery,		hi, Mi Date	20c.	783 Location - 0	City or 1	Fown, Sta	ate
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Lim Pag Iment tant:		4 Donation 5 Ot			naı	rmony Me					007		andove			yland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral S	arvice Lice	nsee									Home I			
	_	Key Skila 23a, Part I. Enter the disea	<u> </u>	nlinations that	anusad the death	Do not optor th	0 Uni	Lver	sity	Blv	d, W.	Si	lver S	Spri		MD 2090
Physician /Medical		failure. List only one	cause on e	ach line.						diac oi	respiratory c	11031, 31	iock, of fical			en Onset and Death
Examiner	1	Immediate Cause (Final d or condition resulting in de				lerotic Cardio	ovascula	ar Dise	ase						\vdash	Dedan
,				Due to (or as	a consequence o	or).										
	ē	Sequentially list conditions if any, leading to immedia:	i, e	Due to (or as	a consequence of	of):									_	
	듵	cause. Enter Underlying (Disease or injury that init									_			1.5	_	
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of Vital Records, P.O. Box 68760 ing Physician: The law requires that the death certificate before this certificate has been signed by the attending physitumeral director, page 2 should be detached for use as the bu	Physician/M	IF FEMALE: 23b. Was decedent pregna	nt in the	23c. If yes	, outcome of preg birth		al death	3	Ectopic p	oregnan	су	12.	3d. Date of o Month		ay	Year
x 61 h cert tendir use a	icia	past 12 months?	_		nant at time of d	acth =	ner (Specif	fy)								
Bo:	hys	1 Yes 2 No 9	Unknow	^{rn} 9 Unki	nown											
		Part II. Other significant		contributing	to death but not	resulting in the u	nderlying o	cause giv	en in Part	t I.			use contrib			
signe lbe d	d by	Sarcoidosis, fati	y liver												- '	Unknown
rds requirements	Completed										24a. Wa aut	s an opsy				dings available in of cause of
e law te has ge 2 s	m d											formed?		eath? ✔ Ye	s	2 No
LR n: Th tifica or, pa	ပိ	25. Was case referred to	nedical		-		26	S.Place	of Death (C	Check o						
Vital Records. ysician: The law requil his certificate has been. director, page 2 should	o Be	examiner?	- 1	Hospital: 1	Inpatient 2	ER/Outpatient	3 DO	A C	other4	Nursing	Home 5	Resid	dence 6	Other	Scene	
1 of V ling Phy After th		1 Yes 2 1 27. Manner of Death	.0	28a. Dat	e of Injury	28b. Time of Ir	njury 28	Bc. Injury	at Work?		28d. Describ	e how in	njury occurre	d		
	i i	1 V Natural 5	Pending	(Mon	th, Day,Year)			1 Y	es 2 []	No						
ivisior Or Attend after death Director:	icat	2 Accident	Investiga	28e Pla	ace of Injury - At h	home, farm, stree	et, factory, o	office bu	ilding, etc.		28f. Location	(Street	and Numbe	r or Ru	ral Route	Number, City
Division of Vital Records, P.O. tale or Attending Physician: The law requires that the safter death. After this certificate has been signed by led in by the funeral director, page 2 should be detact	Certification:	3 Suicide 6 Homicide	Could no determin	it be							or Town					
D Iospital 4 hours: 'uneral		29a. Certifier 1 Cortif	ving Physi			dge, death occur	red at the t	time, dat	e and plac	e, and	due to the ca	iuse(s) a	and manner	as state	=	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	(Check only one) 2 Medic	al Examin	er:On the basis	of examination	and/or investigat	ion, in my	opinion,	death occ	urred at	the time, da	te and p	lace, and du	e to the	e cause(s)
To the within To the comple	Med	29b. Signature and title of		and manner	stated.			License					I. Date signe			
10+1	_	1	RA		110			O.C.N	1.E.			Ap	ril 3, 200	7		
(0,		exarker	1	eco	MUD	m 23a)							_		-	
		30. Name and address of Tasha Greenber		(1	use of death (Itel Medical Exar		Penn St	reet, E	Baltimor	e, MD	21201					
-	tate			La Contraction of the Contractio	Registrar's Signa		AS -								-	
Pogis	ualle	31. Date filed (Month Day	3 20	Ul Fra	allien .	7. 4000	ER J									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 April 10, Frances W. Shapiro 8:25 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth
(Month, Day, Year)
April 15, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months 1 □ M 2 🖺 F Days Hours Min. Washington DC 1920 578-18-5672 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Chevy Chase Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4550 North Park Avenue #210 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: 3X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Witt Dora Kotz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lawrence E. Shapiro - Son 3 Seabreeze Place Norwalk CT 06854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State B'nai Israel Cong. Cemetery 4/13/07 Oxon Hill, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityDanzansky-Goldberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852 Donald 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnuemonia . Due to (or as a consequence of): Plural Effusions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA 1 XInpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

\(\foatsize \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 \(\sum \) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

MD

Director

Funeral

þ

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a.4 permany lighty or other traumatic event, the Medical Formany lighty or other traumatic event, the Medical Formatic Process.

law requires that the death certificate be executed physician and is the burial-tran signed by t d be detach certificate this

Box 68760, σ. Records, Division or Vital or Attending Physician: After within 24 hours after death.

To the Funeral Director: A

Examine

Physician/Medical þ Completed Be မ Certification:

1X Natural

2 Accident

3∏ Suicide

29a. Certifier

4 Homicide

(Check only one) 29b. Signature

31. Date filed (Month, Day, Year)

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natasha Prtina Haag MD 8600 Old Georgetown Road Bethesda MD 20814

APR 13

5 ☐ Pending investigation

6 Could not be determined

egistrar's Signature Waller .

(Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For State Registrar 1. Decedent's Name (First, M		State of	Marylar	nd / Depa	artme rtifica	nt of H	lealth a	and M	ental l	Reg	ene ()	07	1 3 7 0 0
	Physici /Medic		Henry Ch	aunce								April			Year	1:24 A M
	Examir	er	4a. Facility Name (If not institu							Location (of Death				y of Death	
	30 m		Prince George 5. Social Security Number	6. Sex			last birthday)		er 1 Year	L y If Under	24 Hrs	Q Data a	Dieth			eorge'
***	Funeral Director		579–56–4358		v 2□F /.	63	Yrs.	Month		Hours	Min.	8. Date of (Month	Day, 1	1943		place (State or Foreign ntry) •C•
	pu &		Usual Residence of Decedent 10a. State 10b. Cou			10c Cit	ty, Town or Lo	ncation								10d. Inside City Limits
	Maryla -f ehor	tor	655	e Georg	e's	100.01	Landox									1X Yes 2 □ No
	with the	i Direc	10e. Street and Number 7506 Hawthome	Street				10f. 2	ip Code 207 8	5			100	g. Citizen of U.S.	What Cou	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Iteme 23e or 28e-f ehow amy injury or other traumatic event, the Medical Examinational Earth at must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 🔀 1 3 Widowed 4 Divor	Married	. Was Decede Armed Force 1 X Yes 2 If Yes, Give Year or Date	s? 7-6 □No 7-6			edent of H ecify Cuba 2 X No	ispanic Ori n, Mexicar Specify:		cify Yes o Rican, etc.	r No-	Bla	ick, White,	can Indian, etc. erican
15-0	in 72 he n "natu	Completed	(Specify only hi		completed)		16a. Dece (Give life.	kind of v	ual Occupa ork done o use retired	during mos	t of worki	ng		6b. Kind of E		•
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and	ild be file fental Hyg ked othe	To Be C	17. Father's Name (First, Mide Charles Battle		Sr.							(First, Mic	_	aiden Suma S	me)	
Mary	and 2 should ealth and Men n 27 le marke ser traumatic		19a. Informant's Name/Relati		, Print)			•		and Number				City or Town	, State, Zij	Code)
Baltimore, Maryland 21215-0036	Pages 1 and Heat of Heat of Heat of Heat of Heat III It It It of Heat III or other		20a. Method of Disposition 1 Surial 2 Cremati 4 Donation 5 Othe		moval from Sta	ate	Place of Disponentery, createry	matory of	other plac		4 <u>-</u> 17	ate -07		oc. Location eltenha		own, State
Balti	permit. I Departm Imports: any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bonnette & Ac 2504 28th St., N.E., WDC 20018											c. Fur	eral H	bre Inc.
Sty.	Physician /Medical Examiner		23a. Paper. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	a.	Fatal	h line.	annhyth		ode of dyin	g, such as	cardiac o	r respirato	ry arres	st,		Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and sage 2 should be detached for use as the buriat-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. c. d.		as a conseq										
O. Box 6	that the death certificated by the attending pictures as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	230		n 2 ☐ Feta it at time of c	Ideath 3	Ectopic Other (pregnancy specify)						ate of deliv	ery Day Year
ds, P.	w requires that s been signed b should be deta	by	Part II. Other significant con	ditions contr	ibuting to deat	th but not res	ulting in the u	inderlying	cause give	en in Part I	•			cco use con		he cause of death?
Division of Vital Records,	iician: The law req certilicete has beer rector, page 2 shou	Completed										а	Was an utopsy erforme		Were autoprior to codeath?	opsy findings available impletion of cause of 2 No
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ō	Physician: r this certition ral director,	. To	1 ☐ Yes 2 ♣ No 27. Manner of Death		1 ☐ Inp 28a. Date of		ER/Outpatier 28b. Time o		,OA	4 🗆 140				ce 6 Ott		(y)
O	Attending I r death. ector: Atter by the tuner	ation	1 X Natural 5 ☐ Pe 2 ☐ Accident inv	nding estigation	(Month,	Day Year)	Injury	м	28c. Injun Worl	k? Yes 2□				,,		
DIVIS	al or Attendatis after deati	Certification;	3 ☐ Suicide 6 ☐ Co	uld not be ermined		Injury - At h , etc. (Special	ome, farm, str	reet, facto	ery, office		2		on (Stre		ber or Run	al Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: Atter this certificate his completely litled in by the tuneral director, page	edical C	29a. Certifier 1 Certifier (Check only one) 2 Medi	fying Physical Examine	cian: To the best	is of examina	owledge, deat ation and/or in	h occurre	d at the time on, in my o	ne, date an pinion, dea	nd place, a	and due to ed at the ti	the cau	ise(s) and m e and place,	anner as s and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of cer	triier	//			2	9c. Licens	e number	1		290	d. Date signe	ed (Month,	Day, Year)
	90)	fee	6			058	145	+			4-1.	2-07	Z
0	A (9)		30. Name and address of per	on who com	3001	of death (Iter	n 23a) (Type.	Print)	Che	895: everl	ly 1	UD	20:	785		
	Sta Registi		APR 1 3 2007	ear)	32. Reg	istrar's Signa	ature									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** CLAY LEWIS SELLERS APR 3 2007 A^M 11:41 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PARKING GARAGE - BLDG 55 - NNMC BETHESDA MONTGOMERY 8. Date of Birth (Month Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Hours Country) Months Days 28 Yrs. 228-23-5041 Diréctor Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits or itams 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20902 11345 King George Dr. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 DXYes 2 DNo 1f Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itam any injury or other traumatic event. The Market of Once. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo Specify Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) General Surgery Internship 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clete M. Sellers Libby Eye 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica D. Cross/Wife 6880 Gallop Dr. Cordova, TN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/16/07 Chantilly, VA Cremation Center 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murphy Funeral Home 4510 Wilson Blvd. Mason Arlington, Va 22203

234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MULTIPLE BLUNT FORCE INJURIES /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ō Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 🗌 Yes 2♥ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate Yes Yes 1 Yes 2 □ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) X Yes 2 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year APR 3 2007 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 11:41 AM 5 Pending investigation 1 Natural 2 🛣 No FELL FROM APPROX. 90 FEET after death Director: / death 2 Accident 3 X Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a BLDG 55 NNMC COMPOUND BETHESDA Hospital MARYLAND 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier ပ APRIL 3 2007 ME 65453 (FL) 30. Name and address of person who completed cause of death (It em 23a) (Type, Print) ARMED FORCES INSTITUTE OF PATHOLOGY MONAGHAN CDR TIMOTHY D. MC J USN ROCKVILLE MD 3 32. Registrar's Signature Registrar

		For State	State of Maryland	-	tment of H		Mental Hy	7 1111 /	13702
		1 - State Registrar 1. Decedent's Name (First, Middle, Last	1	Certi	ilcale of L	Jeani	2. Date of De	Reg. No.	3. Time of Death
Physici	an							L 7, 2007	
/Medi	cal	Chester Adam_	Schmaelin		4h City Town or	Location of Don		4c. County of Dea	5:08 p M
Examir	ier	4a. Facility Name (If not institution, give		•	4b. City, Town, or				
<u> </u>		Hillhaven Assiste 5. Social Security Number 6. Se		t hirthday)	Adelph If Under 1 Year		8. Date of Bir	Prince (
Funeral Director	١.		M 2□F 91.		Months Days	Hours Min			rthplace (State or Foreign ountry) V York
		Usual Residence of Decedent	91				10-10	1)1) Nev	VIOIK
ylan		10a. State 10b. County	10c. City, 1	Town or Loca	tion				10d. Inside City Limits
B-f s	ctor	Maryland Prince G	eorge's Ade	1phi					1 X Yes 2 □ No
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
23a	rail	3210 Powder Mill	Road	, .	20783			U.S.A.	
or deg	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wa	as Decedent of Hi res, specify Cuba	ispanic Origin? (S in, Mexican, Puei	Specify Yes or No rto Rican, etc.)	14. Race - Arr Black, Wh	
s affe	by F	1 ☐ Never Married 2 ☐ Married	1 X Yes 2 □ No If Yes, Give	1 []Yes 2∏ No	Specify:		Specify:	
hours in Exe		15. Decedent's Edu	Year or Dates: WWII	16a Decede	nt's Usual Occupa	ation		16b. Kind of Busines	hite Mindustry
in 72	Completed	(Specify only highest grad	le completed)	(Give kil	nd of work done of NOT use retired	during most of wo	orking		,
d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Pain	ter Fore	man		U.S. Goven	nment
Hyg ethe	BeC	17. Father's Name (First, Middle, Last)					me (First, Middle	, Maiden Surname)	· · · · · · · · · · · · · · · · · · ·
Viano vuid be file Mental Hy nrked oth	To B	Adam Schmaeling				Louisa	Isherwo	od	
shound N		19a. Informant's Name/Relationship (T)	(pe, Print) Personal	19b. Mailing	Address (Street a	and Number or A	ural Route Numb	er, City or Town, State,	Zip Code)
Ind 2 alth a 27 is		Don Messinger, Es		ive 474	3 Sellm	an Road.	Beltsv:	ille, Marvl	and
S 1 a of Hear of hear		20a. Method of Disposition	20b. Plac	ce of Disposit	tion (Name of tory or other place		Date	20c. Location - City of	
DESILITION INTERPLIATION ZIZIONOS permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: it item 27 is marked other then "naturel", or iteme 23e or 28e-f show any injury or other traumatic event, the Medical Exempliar must be natified at once.		1 XBurial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	removal from State	•	Cemeter	1	3/2007	Cheltenha	m, Maryland
mit. porte y inju		21. Signature of Emeral Service License			Name and Addres				timore Ave.
0 8858		Maluje Cont	× 101373	Gas	ch's Fur	neral Ho	me, P.A.	Hyattsvi	11e, MD 20781
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the death.						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	_a Pneumonia						Onset and Death
/Medical		resulting in death)	Due to (or as a conseque	nce of):					24 Hours
Examiner		Conventially list appditions	b						
D #	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	nce of					
ocuter nd transi	Examin	Cause (Disease or injury that initiated events	c						
rou, e be executed /sician and e burial-transit		resulting in death) Last	Due to (or as a consequer	nce of):					
ate b hysic the b	licai		d						
Aecords, F.C. BOX 06/00, le law requires that the death certificate be executed has been signed by the attending physician and ge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:							
ath cer	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de	eath 3□E	ctopic pregnancy			23d. Date of d Month	elivery Day Year
the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of deal 9☐ Unknown	th 5∐(Other (specify)				
ecords, r.O. law requires that the as been signed by th		Part II. Other significant conditions co	ntributing to death but not resulti	ing in the und	erlying cause give	en in Part I	23e, Did	tobacco use contribute	to the cause of death?
signe signe	ģ	,			only mig oddoo g	O			Probably 4 Unknown
ecords faw requires as been sign	Completed						· · · · · · · · · · · · · · · · · · ·		
e taw has l	mpi						24a. Was auto		autopsy findings available completion of cause of
ate Th	ပိ						1 ☐ Yes		s 2 No
VICEN: I	Be	25. Was case referred to medical examiner?	Hospital:		2□ DOA Oth	or	eath Check only		
OT VICA Physicien: this certific ral director,	. To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 Inpatient 2 EF	R/Outpatient 8b. Time of	3 DOA 28c. Injun	4 X Nursing	1	how injury occurred	ecify)
SION tending leath. tor: After the fune	tion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Worl	k? Yes 2 ☐ No		mon many coodings	
Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At hom	e, farm, stree			28f. Location	Street and Number or I	Rural Route Number,
after d Direct	Certification:	4 Homicide	building, etc. (Specify)		, , ,		City or To	wn, State)	
Hospital Pospital Pospital Pospital Hospital Hospital		29a. Certifier 1 X Certifying Phy	sician: To the best of my knowle	edge, death o	occurred at the tin	ne, date and plac	e, and due to the	cause(s) and manner	as stated.
UNISIG	Medical	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	n and/or inve	stigation, in my o	pinion, death occ	urred at the time	date and place, and di	e to the cause(s)
To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of centiler	118111		29c. License	e number		29d. Date signed (Mod	nth, Day, Year)
AR		Magm	MADNING		D315	63		April 10,	2007
AC.		30. Name and address of person who o	ompleted cause of death (Item 2	(Type, P					
10H(6)		Charles M. Benner				#205, S	Silver S	oring, MD 2	0901
LATER CRACK	ate	31. Date filed (Month, Day, Year) APR 1 3 2007	32. Registrar's Signatur	гө					
Regist	rar	WLU I O TON	cen D. Sper	W					

07-03048	
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)7-03	048 Deyande S	mitl	Please Type or Print in Black Indelible Ink. En State of Maryland / Department of Healt			gible.	
Alleli	Deyande C		1- For State Certificate of Death			200	7 1370
	Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Deat		3. Time of Death
Medi	cal Exami	ner	ALLEN DEYANDE SMITH		Month April 21, 2		0725 hrs
			4a. Facility Name (if not institution, give street and number) 4b. City, 1 8206 B Mapleville Road Boons	Fown, or Location of D Sboro	eatn	4c. County of Deat Washington	n
	Funeral			er 1 Year If Under 2	4Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bi	rthplace (State or
	Director		219-66-2199 1X M 2 F 51 Yrs. Month	s Days Hours	Min. OCT. 3	3, 1955 C	ountry IRGINIA
	ý.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	d How ai		MARYLAND WASHINGTON BOONS	SRODO			1 Yes 2 X No
	Maryland 28a-f show any 1 at once.	Director	10e. Street and Number 10f. Zip		1	0g. Citizen of What Cou	untry?
	the Na or 2		8206-B MAPLEVILLE ROAD	21713		U.S.A	١.
	th with terms 2 st be n	Funeral		ent of Hispanic Origin? fy Cuban, Mexican, Pu		- 14. Race - Ame White, etc.	rican Indian, Black,
	her der ", or i er mu		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	X No specify:		Specify:	WHITE
	ours a	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual during most of working	Occupation (Give kind		16b. Kind of Business	
٩	50 in 72 h han "n lical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		o retired)	DUTI DING 6	NADAL V. DICT
è	d with d with rgiene.	mo	12 PO(OLER 18.Mother's N	Name (First, Middle, I		SUPPLY DIST.
2	Z1Z15-UU36 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be (ROBERT SMITH	SHELB	Y BREEDEN		
3	should should and Me	٩		•		nber, City or Town, State	
	and 2 sho lealth and tem 27 is traumati	-	20a. Method of Disposition 20b. Place of Disposition (Nar		Date	SBORO, MD 20c. Location - City o	21713 r Town, State
	nore		1 X Burial 2 Cremation 3 Removal from State crematory or other place; 4 Donation 5 Other Sector: MOUNTAIN VIEW		1/2//2007	CHADDSBIID	G, MARYLAND
=	BAITIMOTE, MID 21219-0U30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and	Address of Facility	7606 01	ld National	
			Paul M. Dean BAST F		^{4E} Boonsbo	oro, Maryla	nd 21713
	Physician Medical		failure. List only one cause on each line.	or dying, such as card	liac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cirrhosis of liver Due to (or as a consequence of):				-
	′	_	Sequentially list conditions, lif any, leading to immediate Due to (or as a consequence of):				-
		Examiner	If any, leading to immediate Due to (or as a consequence of): (Disease or injury that initiated C				1
	ted I Insit	Exa	events resulting in death) Last Due to (or as a consequence of): d.				
	that the death certificate be executed that the death certificate be executed ned by the attending physician and detached for use as the burial - transit	lical	MENDED AMENDED AMENDED PER 1,27, per ME, g868, 6/7/07 T	יי יי			
9	760, cate be physic the bur	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	•
Š	certifi ending use as	cian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of 5 Other (Spe		regnancy	Month	Day Year
	BO) e death the att	hysi	1 Yes 2 No 9 Unknown g Unknown				
0	LIVISION OF VITAL RECORDS, P.O. BOX 68/60, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I		obacco use contribute to s 2 ✓ No 3 Pro	
	LIVISION OY VITAI KECOTOS, P. K. To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be deterned.	sted			24a. Was	an 24b. Were a	utopsy findings available
	e law r e has b ge 2 sho	Completed				rmed? death?	completion of cause of
	II KE		25. Was case referred to medical	26.Place of Death (Ch	1 Yes	2 N 1 Y	res 2 No
į	VITA hysicia this ce	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 C	OOA Other N	lursing Home 5	Residence 6 🗸 Othe	er: Scene
٠	n or ding P After funera	on: T	(Month, Day, Year)	28c. Injury at Work?		how injury occurred	
•	Atten Atten rector: by the	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory			Street and Number or R	tural Route Number, City
i	Ital or Illed in Dia	ertif	3 Suicide 6 Could not be determined (Specify)	,,	or Town, S		
	To the Hospital within 24 hours To the Funeral completely fillee		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the	e time, date and place	, and due to the caus	se(s) and manner as sta	ited.
	To the within To the compl	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my and manner stated.		red at the time, date		
		2	29b. Signature and title of certifier	c. License number O.C.M.E.		29d. Date signed (Mo April 22, 2007	oniti, Day, Tear)
			30. Name and address of person who completed cause of death (Item 23a)	*			
SH	-0		Margarita Korell MD. Assistant Medical Examiner 111 Penn Str	reet, Baltimore, I	MD 21201		
		ate	31. Date filed (Month PRYSE) 3 2007 32. Redistrar's Signature	,			
	Regist	12.72					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Apri 2:39 AM 2007 Alice Viola SCALESE 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospita ?
5. Social Security Number | 6. Sex | 7. Age Hagerstown
If Under 1 Year | If Under 24 Hrs. Washington Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthdav) **Funeral** Days Months Hours 1 □ M 2 🗓 F Director Feb. 26 1926 Maryland 215-20-8984 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. Count 1 X Yes 2 No Director Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number an "natural", or Items 23a or 7 Medical Examiner must be n Funeral 949 Chestnut Street 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify. Completed by 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy important: If Item 27 is marked oth any Injury or other traumatic event Be 2 Leonard Ivan Gift Gladys Viola Hoffmaster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patrick Ruffner - Son 13014 Resh Road, Hagerstown, Md. 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/20/07 Hagerstown, Maryland Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic sho Physician shoc /Medical **Examiner** Respirator

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Preumonia P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Yes 2 No 3 Probably 4 Unknown neyenling Stenosy Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Chronic 1 Yes 2 No or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Empatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

062588

29d. Date signed (Month, Day, Year)

April 17th, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2:12AM Linda Lou STENGER 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) Year) Months Days Hours 1 □ M 2 😾 F 66 212-38-7605 June 20,1940 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2x No Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16206 Shinham Road 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife her own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas S. White, Sr. Claire Grace Brunner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 Department of Health a Important: If Item 27 Is any Injury or other trains Thomas W. Stenger 16206 Shinham Road, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hagerstown Crematory 4/18/07 Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Keshiral disease or condition resulting in death) 2 months /Medical Due to (or as a consequence of): Examiner 2 month Imonia Sequentially list conditions, Examine if edy loading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b rector, page 2 s autopsy performed 2 No 25. Was case referred to medic Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 2 Accident (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Owithin 24 h. To the Fun 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number D 44996 opans Rd Boonsboro MD 21713 e of death (Item 23a) (Type, Print) 31. Date filed (Mohth, Day, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

07-02973

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 13707

lliam Douglas Sv		n, Jr. For State	State	of Maryland /	epart <i>Certit</i>	ficate of	Death	a Works	i i iygioni	Reg. N		200	, , , ,
Physician/	Re	rietrar	e (First, Middle,Las	t)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Month	of Death	/ Yea		Time of Death 0630 hrs
Examine	r	William	n Doug	las Swann	, Jr.				April	18, 2007	4c. County	of Death	00001110
į.	4a	Facility Name (i	f not institution, giv	e street and number)		4	b. City, Town, or Newburg	Location of L	Death		Charles		
			news Manor R		(In yrs. last	hirthday)	If Under 1 Yea	r If Under 2	24Hrs. 8. Dat	e of Birth(M	M/DD/YYY	Y) 9. Birthp Foreign	lace (State or
Funeral	-	Social Security N			35	Yrs	Months Day		Min. Feb	ruarv	17.19	972 ^{Count}	Marylane
Director	- 1	219-13-3 sual Residence o		KM 2F	33				100				0d. Inside City Limits
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the N Sa or		15440 M	atthews N	Manor Road		142 10/4	as Decedent of H		n? (Specify Ye	es or No-			an Indian, Black,
h with		Marital Status XNever Marr	ed 2 Marrie	12. Was Decedent Armed Forces?	_	IS. W	es, specify Cuba	n, Mexican, I	Puerto Rican,	etc.)	Wh	ite, etc.	
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irs afte	ବ⊢			or Dates: only highest grade com	pleted)	16a. Deceder	nt's Usual Occup	ation (Give ki	ind of work do	ne 16	b. Kind of E	Business/In	dustry
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Hygi Hygi doth t, the			(First, Middle, Las	Swann,Sr.				Heler	ı Arlen	e Gol	dsmit!	h _	
	e l	WIIIIABI 19a. Informant's N	lame/Relationship	(Type, Print)			ng Address (Str					200	Zip Code) 664
AD 2 shou h and 1 string imatic	-			r./Father		1544	0 Matthe	ws Mar	or Roa	d New	hurg	SVI 1 3	Town, State
e, N 1 and Health Titem	- 1	20a. Method of D		Removal from St		Place of Dispo rematory or o	osition (Name of other place)	cemetery,		1		e,Mar	
Pages ent of int: Il	1	4 Donation	5 Other Spec	ify:	Но	Lv Gho	st Cemet	ery	4/23/	07	155u		St. Mary'
altin	Ì	21. Signature of	uneral Service Lic	ensee MO0)945	22.	Name and Addre	ECHOLS	FUNER	AL HO	ME,P.		Plata,MD 2
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Physician edical	ł	failure List	only one cause on	each line.									Death
aminer	1	Immediate Cause or condition resu		a. Cardiac arr Due to (or as a cons	equence o	f):							
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	iner	if any, leading to	immediate derlying Cause	Due to (or as a cons	sequence o								
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ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate by refear. After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the but	Z/	IF FEMALE: 23b. Was deceded past 12 mor	ent pregnant in the	1 Live birth		2	Fetal death	3 Ectop	ic pregnancy		Mon	th	Day Year
ox 6 tth cert	Physician/M	1 Yes 2		7	at time of d	eath 5	Other (Specify)						
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Division of Vital Records, tal or attending Physician: The law requirers after death. "It Director: After this certificate has been siled in by the funeral director, page 2 should t	o Be	examiner?	2 No	Hospital: 1 Inpa	tient 2	ER/Outpat		Other ₄	Nursing Ho		Residence now injury o	6 Oth	er: Scene
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D ospital hours meral y filled		4 Homici	de		f my knowle	edge, death o	occurred at the tir	ne, date and	place, and due	e to the caus	se(s) and m	anner as st	ated.
Division To the Hospital or Attend within 24 hours after death within 24 nours after death completely filled in by the 1	Medical	(Check only one) 2	✓ Medical Exar	miner: On the basis of e	examination	and/or inves	sugation, miny of	Jillion, acam		e time, date			
To T Com	Med	29b. Signature	and title of certifie	and manner state)			icense numb	er		1		Month, Day, Year)
	120	Pat.	1000	on it	oll	ch us		D.C.M.E.			April 1	9, 2007	
0			address of person	who completed cause	of death (It	em 23a)	. 444 Day	n Stroot	Baltimore,	MD 2120)1		
DB			Aronica-Pollal			al Examine	er ill Per	ıı Sueet,		2.20			
5	State stra		Month, Day, Year)	32. Regi	strar's Sign	K L	book						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 4 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 9;11 p M Lillie Mae Torain April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 1 1 F 61 230-60-8692 Director Aug. 21, 1945 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show notified at 1√2 Yes 2 No Director Prince Georges Hyattsville 10g. Citizen of What Country? 10e. Street and Number death with ral", or items 23a or Examiner must be r 20781 U.S.A. 4203 Oglethorpe Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ ♠No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of the still and Mental Hygiene. and the filed with filed Tis marked other than "natural", or iter any or other traumatic event, the Medical Examiner ury or other traumatic event, the Medical Examiner. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Black Year or Dates: tal Hygiene. d other than "natura event, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Obie Suella Anderson Hughes ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Torain-Husband 4203 Oglethorpe St. Hyattsville, MD. 20781 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If ite any Injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Clinton, MD Resurrection Cem Apr.11,07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linens 22. Name and Address of Facility Hunt Funeral Home 908 Kennedy St.N.W. Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner sequentiary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ Xo Month Day Year has been signed by the le 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown

Be Completed by certificate ha ဥ Certification: within 24 hours after death.

24a. Was an autopsy 1□ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2□ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ MNo

5 ☐ Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

and manner stated

1 Inpatient

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XER/Outpatient 3 □ DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29a. Certifier (Check only

27. Manner of Death 1 D Natural 2 Accident

3 ☐ Suicide

4 Homicide

29b. Signature and title of certifie

29c. License numbe

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

APR 1 3 2007

32. Registrar's

State Registrar

Medical

DHMH 17 Rev 1/2001

Hospital or Attending Physician:

To the

funeral director,

After this

Certificate of Death

Registrar

State

N

Richard Pather

APK 13 2001

31. Date filed (Month, Day, Year)

14)

MD 1328 Southern avenue JE

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20055120

State 310 Warkinglon DC 20032

April 9 200)

State of Maryland / Department of Health and Mental Hygiene UU

1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 1:00 P APRIL WILLIE MAE TUGGLES 10 2007 /Medical 4a. Facility Name (If not institution, give street and number)
FT. WASHINGTON HEALTH & REHAB 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGES FT. WASHINGTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) ALABAMA 8. Date of Birth 5 Social Security Number **Funeral** MARCH14°,1901 Hours Min Months Days 1□M 2,□F 106 263-46-1597 Director Usual Residence of Decedent with the Maryland 10c. City Town or Location 10d. Inside City Limits 10a State 10b County r than "natursi", or itsma 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Director ACCOKEEK CHARLES 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20607 USA 13201 SUNTUM CT. Pages 1 and 2 should be filed within 72 hours after death anent of Heelih and Mental Hygiene.
smit: if feam 27 is marked other than "naturel", or Itama 23, and other fraumatic event, if a he slical Endon ar manal ary or other fraumatic event, if a he slical Endon ar manal. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: BLACK 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CLEANING HOUSEKEEPER UNK. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) EMMA NORMAN UNKNOWN P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ACCOKEEK, MD 20607 13201 SUNTUM CT. ZARAGONA TUGGLES/GRANDSON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
important: if ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEM. 4/17/07 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility STRICKLAND 6500 ATTLENTOWN RD. CAMP 21. Signature of Funeral Service Lic FUNERAL SERVICES AND 20748 6500 ALLENTOWN RD. Howar Approximate Interval Between Onset and Death 10 YRS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR DISEASE YRS. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner nding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by sign. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death [Check only one] Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medicai Certification: tXXVatural 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 045365 06-12-20 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL SIDAROUS, MD 11701 LIVINGSTON RD. FT. WASHINGTON, MD 20744 31. Date filed (Month, Day, Year)
APR 1 3 2007 32. Registrar's Signature State

DHMH 17 Rev 1/200

Registra

	Please For Amend #5 Per] 1- Registra MEND#26per MD4	Type or Print INPtate of Ma /13/07, BW, Mo	7/4/10/ 9 <u>A</u> P		ealth and	Mental Hyg		ble.	13711		
an	1. Decedent's Name (First, Middle, La: Richard Herman					2. Date of Dea Month	Day	Year	3. Time of Death		
al	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat	April 8	4c. County	of Death	2:55 A M		
er	Residence_#4925		gomer	у							
	5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs		, Year)	9. Birthpi	Birthplace (State or Foreign Country)		
	160-18-7309 Usual Residence of Decedent	M ZUP	89 Yrs.			August 2	21,1917	Pen	nsylvania		
	10a. State 10b. County		10c. City, Town or L		10	Od. Inside City Limits					
Completed by Funeral Director	MD Montgome	ry	Bethesda	a					1 ☐ Yes 2★ No		
Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Coun	try?		
era	4925 Battery Lan	e #406 12. Was Decedent Ev	varial IS 13	20814 Was Decedent of Hi	enanie Origin? (9		J.S.A.	e - Americ	an Indian		
Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		If Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	Blac	k, White,	etc.		
l by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1943	1∐Yes 2√2No	Specify:		Specify	Specify: White			
etec	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupa	luring most of wo	rking	16b. Kind of Bu	usiness/Inc	dustry		
Jup	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired		TI T	.S. Gov	ornmo	n t		
Be Co	17. Father's Name (First, Middle, Last)	5+		10100	18. Mother's Na	me (First, Middle,			:11C		
To B	Charles H. Vogt				El s a Vog	ţt					
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
	Lester P. Needle/Trustee 7029 Haycok Rd. Unit I, Falls Church, VA 22043										
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) King David M. Garden April 10, Falls Chur										
	 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen 		10, Falls Church, VA								
Diana L Daney 7482 Lee Hwy., Falls Church, VA 2204											
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
	Immediate Cause (Final disease or condition resulting in death) Respiration Due to (or as a consequence of): PLEUDAL EFFUSION								Onset and Death		
	resulting in death)	Due to (or as a	consequence of):/								
10	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a									
amine	Cause (Disease or injury	200 10 (01 23 2									
	that initiated events resulting in death) Last	Due to (or as a	consequence of):								
Ical	(d									
Med	IF FEMALE:	00. 14									
ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	e of delive nth						
ysic	1 Yes 2 No 9 Unknown	9□ Unknown	mo or douth of								
Completed by Physician/Medical Ex	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute								e cause of death?		
ted	AMAC FIGHIL	3 Proba	ably 4 □Unknown								
nple	GATTNOUSOShag.	eal Ruft	ux Dida	ease		24a. Was a autops	n 24b. V	Vere autop	osy findings available apletion of cause of		
So	Prostate HUD	ur plasia				perform 1 Yes	ned?	leath?	2 No		
Be	25. Was case referred to medica examiner?	Hospital:		Othe	-	ath (Check only or					
n: T	1 ☐ Yes 2 ZNo 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day)		of 28c. Injury	at	28d. Describe h)		
atio	1 ★Natural 5 Pending 2 Accident investigation	il and the same of	Year) Injury	Work M 1 □ Y	? 'es 2 □No						
rtiffe	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined							er or Rural	Route Number,		
Medical Certification; To Be	29a. Certifier 192 SertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s										
dice	(Check only 2 Medical Exam	niner: On the basis of e and manner state	xamination and/or in	vestigation, in my op	inion, death occu	rred at the time, d	ate and place, a	and due to	the cause(s)		
Me	29b. Signature and title of certifier	611.		29c. License	number	2	9d. Date signed	(Month, E	Day, Year)		
	fllege/ H	the same of the sa		H4.	1834		4/10/0	57			

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

10

Physician /Medical Examiner

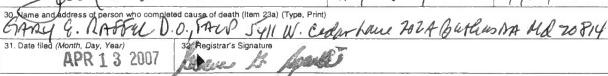
Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, Ira Medical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

State Registrar



			1- State of Maryland State of Maryland		artment of Hea tificate of De		Re	g. No.	13712		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) GREGORY M. WHITE				2. Date of Deat Month APRIL (Day Year 18, 2007	3. Time of Death 12:12 p ^M		
- 12	Examir Funeral		4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. las. 1000 20 5 1000 20			S Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	inde1		
	Director Mou		579-08-1709 36 Usual Residence of Decedent 10a. State 10b. County 10c. City, 1		cation		Oct. 7,	1970 Was	thington, D.C.		
	vith the Ma	Director	10e. Street and Number	hing	10f. Zip Code		10	0g. Citizen of What C	•		
350	4 within 72 hours after death with the Maryland liene. r then "natural", or Iteme 23a or 28e-1 ehow the Madical Examirar must be notified at	by Funeral	5809 3rd Place N.W. 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		20011 Was Decedent of Hisparity Yes, specify Cuban, Natural Yes 2 No S	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	United St 14. Race - Am Black, Whi Specify: B1	erican Indian, ite, etc.		
21212-0036	d within piene. r than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	dent's Usual Occupation kind of work done during the DO NOT use retired)		ng	16b. Kind of Business	s/Industry N/A		
ryland	should be tiled ad Mental Hygi marked other matic event, I	To Be C	17. Father's Name (First, Middle, Last) Dwight Gregory White 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	18	Barbara	Jenkin		Zip Code)		
lore, Ma	iges 1 and 2 should nt of Health and Mer if Item 27 ie marke or other traumatic		Barbara Howell / Mother 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	809 e of Dispo etery, cren	3rd. Place sition (Name of natory or other place)	N.W. Wa	shington	n, D.C. 2	20011 r Town, State		
Daitim	permit. Pages 1 Department of H Important: If Ite any injury or ot ance.		4 Donation 5 Other (Specify) Rest	rrec	tion Name and Address of Alexander 5538 Marib			Clinton, M			
00/00,	Physician pe executed // Medical Examiner as the burial-transit as the burial-transit	fedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence	ce of):	iotic Cai	ndioVa	asculai	13:500	Interval Between Onset and Death SE Y LONG		
.O. Box	t the death certiff by the ettending ached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year		
ecords, r	law requires that the de tes been signed by the or s 2 should be detached	ompleted by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Can do my op ashy Gnoxic Encephalopershy Hyper tension Poly cyste Kickney is its last autopsy findings available prior to completion of cause of								
vital n	Physician: The lav this certificete hes ral director, page 2	o Be Con	25. Was case referred to medical examiner? 1 Yes 2 10 Hospital: 1 Inpatient 2 15		1 04		perform	No 1 ☐ Ye	s 2□No		
בום	Afte tune	ertification: T	To inpatient 2 is a Position of the Control of the								
	To the Hospital or Attent within 24 hours atter death To the Funeral Director: completely tilled in by the	fedical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle and manner stated.	dge, death and/or inv	vestigation, in my opini	on, death occurr	ed at the time, da	ate and place, and du	e to the cause(s)		
)	2 1 2 50 (le)	M	30 Name and address of person who completed cause of death (Item 2:	e Gn	29c. License nu		1	9d. Date signed (Mon			
	Sta	te	31. Pate filed (Month, Pax, Year) 32. Registrar's Signatur	Vee	ensbury	Rd My	atts vi	11- MD.	20757		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Month **Physician** 9 Geraldine L. White 01 8:17 P. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bowe Health 6-enges If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 11/21/17 Months Days Hours Min. 1 ☐ M 2 🔀 F 89 579-44-9077 Yrs. Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Md. P.G. Bowie Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö 20716 U.S.A. 16010 Excalibur Road 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: ģ 3 ₩ Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny injury or other treumatic event, the Ma Elementary/Secondary (0-12) 12th College (1-4or 5+) Domestic Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Grayson Louise Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Constance Kimbles/Daughter 18301 Chestnut St., Lexington Park, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cem. 4/16/07 Suitland, Md. 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee W. Crati any 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) crioscherotic sertenine Heart Physician /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ending physicien and use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth in the past 12 months? 2 Fetal death 3 Ectopic pregnancy ò Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. detached cate has been signed by I page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 🗆 No 1 Yes 2 - No 1 Tyes Division of Vital Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ဥ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner Death 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending death. M 1 Tes 2 No investigation within 24 hours efter death To the Funerel Director: 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only one) 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who com

31. Date filed (Month, Day, Year) APR 1 6 2007 eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

• •			
State of Maryland	Department of Health	and Mental Hygie	ne

			For State Registrar	State of Marylan	-	ertificate of L			iene eg. No.	
	0		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death
	Physicia /Medic		Dorothea M.	Wood				April :		5:06PM M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			12101 College Pla			Princess			Somerset	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.		/) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
	Director		219-20-8420	80	Yrs.			09/18/19	926 <u>Mar</u>	yland
	and w	1	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or	Location				10d. Inside City Limits
	f sho	0		-						1XYes 2 □ No
	28e	Director	MD Somerset	Pr	incess	S Anne 10f. Zip Code		1	0g. Citizen of What Cou	antry?
	3a or	<u></u>	12101 College Pla	100		2185	3		USA	
	death ms 2	Funeral		12. Was Decedent Ever in U	l.S. 13	I. Was Decedent of Hi. If Yes, specify Cubar		ecify Yes or No-	14. Race - Amer	
1215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic avant, the Madical Examination ust be mailfied at sine.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:	Mican, etc.)	Black, White	hite
ž	2 hou	ted	15. Decedent's Edu		16a. Dec	edent's Usual Occupa	ition		16b. Kind of Business/I	
2	within 7; ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Giv	re kind of work done of DO NOT use retired,	uring most of work)	ang		
_	filed witl Hygiene other the	E O	12	none	l I	Homemaker			Own Home	
g	be filed tal Hygie d other avant, t	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, i	Maiden Sumame)	
<u>a</u>	should bind Ments marked umatic a		Kenneth Tidrick				Marie Ti	idrick		
Maryland 2	2 sho and is ma		19a. Informant's Name/Relationship (Ty	pe, Print)					, City or Town, State, Z	
	and sealth m 27		Larry Wood/Son						Anne, MD 21	
ore	of Hi of Hi of itar		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ P		Place of Dis cemetery, ci	position (Name of rematory or other place	θ)	Date	20c. Location - City or 3	Town, State
Ξ	Pages ment of ant: If its		' 4 ☐ Donation 5 ☐ Other (Specify)	Sa		ry Cremato		6/2007	Salisbury,	Maryland
Baltimore,	permit. Page Department Important: If any injury or		1. Signature of Funeral Service Licens	88	F	22. Name and Addres	s of Facility eral Home	:		
	70 7 8		ATTION TOWN	May MOO	295 1	.1673 Some	set Aver	ue, Prin	icess Anne,	MD 21853 Approximate
		/	23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that daused the dea ne cause on each line.	th. Do not e	enter the mode of dying	g, such as cardiac	or respiratory arr	8 ST,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Oronary Arkey Dilecte							
Н	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	0.0:	7-	1		l
H		<u></u>	Sequentially list conditions,	Due to for as a gonser	y O C	erdid.	-noe c	The		
	pet 1sit	nine	cause (Disease or injury			42400				
	and and al-trai	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	qu ce of):	me !!		10	0	€ 2 yes
68760	ficate be executed physician and is the burial-transit	la la		· Co	-1 Lie	- Ulca	er with	_ blee	6	- Deers
89		edical								24
Вох	n cert	Z	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn		3 7 5			23d. Date of deli	
m	death e atte	20	in the past 12 months? 1 \(\sum \) Yes 2 \(\sum \) No	1 ☐ Live birth 2 ☐ Fet:		3 □Ectopic pregnancy 5 □ Other (s <i>pecify)</i>			Month	Day Year
P.O.	t the by the	Physician/M	9 ☐ Unknown	9□ Unknown						
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	by P	Part II. Other significant conditions co	ntributing to death but not re	sulting in the	underlying cause give	en in Part I.	3 -	bacco use contribute to	
ğ	en sig	ed	1 Cheupsate	d Arthro	71			1)**	es 2 No 3 Pr	obably 4 Unknown
ည	law re as be 2 sh	ple	By Det	ciency				24a. Was a autop		topsy findings available completion of cause of
Vital Records,	The ate ha	Completed	Ataloini	24				perfor 1 ☐ Yes	med? death?	2 No
ā	sian: artifica	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	ne)	
	hysic his ce I dire	2	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpat		4 Nuising n		ence 6 Other (Spec	cify)
0	ding Pl h. After ti tunera		27. Manner Peath 1 atural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injur	y Worl		28 escribe h	ow injury occurred	
<u>S</u>	eath. or: A	catl	2 Accident investigation				Yes 2 □ No			
Division of	l or Ati after d Diract in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, fam, ify)	street, factory, office		City or Tow	treet and Number or Ru n, State)	irai Houte Number,
	urs a			l secondario		== 1000		and due to the	(a) and manner as	stated
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kn iner: On the basis of examin and manner stated.	ation and/or	eath occurred at the tin rinvestigation, in my o	ne, date and place pinion, death occu	red at the time,	date and place, and due	to the cause(s)
	To tha within 2 To tha complet	Mec	29b. Signature and title of cartifier	and mainer stated.		29c. Licens	e number		29d. Date signed (Monti	h, Day, Year)
)	⊬ ≩ F 8		40 AM 11	2			7053W	(2)	04-16-	- ACKO
			30. Name and address of person who c	ompleted cause of death (ite	m 23a) (Tur	na Printt)	1			
6	EB		Tolan Ish He	ile mo	051	of She	& Suit	- 105	Pocemelo	MO 21851
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature				(410)	MD 21851
.00	Regist	rar	APR 1 7 2	2007 Elecu	J.	Docute			-	

			1 - For State Registrar	State of Marylar	•	artment o		h	F	Reg. No.	007	13715
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) Bernice A 4a. Facility Name (If not institution, give s	Altman Water	nan Waters and number), 4b. City, Town, or Location of Death				2. Date of Death Month Day Year 4c. County of Death			U // 4W
	Funeral Director		5. Social Security Number 6. Sex 218-16-1321	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Y	ear If Und ays Hours	er 24/firs. 8.s Min. J	Date of Birt (Month, Datune 23	h y, Year) , 191	9. B	irthplace (State or Foreign Country) Virginia
	the Maryland 7 28a-f ehow Dalling at	Director	10a. State 10b. County Maryland Harfo 10e. Street and Number	ord Havre de Grace						10d. Inside City Lin 11 Yes 2 ☐ 10g. Citizen of What Country?		
36	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dept innent of Health and Mental Hygiene. Important: if item 27 is marked other then "neturel", or iteme 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be mailled at ODGs.	by Funeral	735 John Smith Str. 11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	Ceet 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	J.S. 13.	21078 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 1 □ Yes 2⊠ No Specify:				U.S.A. Yes or No- In, etc.) 14. Race-American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Aberdeen Proving Grou Aberdeen, Maryland rst, Middle, Maiden Sumame) Ce Sanger oute Number, City or Town, State, Zip Code)		nerican Indian, nite, etc.
Maryland 21215-0036	iled within 72 hou tygiene. ther then "neture nt, the Madical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) Twelve Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk Typist				roving Ground			
Maryland	d 2 should be f th and Mental ! ? Is marked ot traumatic ever	To Be		pe, Print) (son)								
Baltimore,	t. Pages 1 and the control of Healing them 2 stant: If item 2 stant or other control of the cont		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	20b. lemoval from State	Place of Disponentery, cre rford Me	osition (Name of matory or other morial Ga	of place) ardens	Dat 04/21	• /07	20c. Locat Aberd	ion - City o	or Town, State Maryland
Ba	Deported Important	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appl									P. A. Approximate Interval Between Onset and Death	
8760,	Physician /Medical Examiner but sicien and but sicien and stree paral-transit street paral-tr	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									2. Nouge
.O. Box 6	Physicien: The law requires that the deeth certifics this certificate hes been signed by the ettending phrait director, page 2 should be detached for use estimal director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live birth 2 Fet	f yes, outcome of pregnancy t						23d. Date of delivery Month Day Year	
Records, P.	w requires that been signed by should be deta	<u>م</u>	0	Compression Fracture lumber spine 10						tobacco use contribute to the cause of death? Yes 2 (A)No 3 Probably 4 Unknown		
	ion: The la raificate hes	Be Completed	25. Was case referred to medical examiner?	24a. Was an autopsy performed: 1 ☐ Yes 2 ☑ 1 26. Place of Death (Check only one)						osy ormed? 2 No	prior to completion of cause of death?	
Division of Vital	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	၉	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c.	Other: 4 1 Injury at Work? 1 Yes 2		5 ☐ Resid			pecify)
Divi	pital or Att ours after do erel Direct	i Certification:	3 Suicide 6 Could not be determined									
	To the Hospital or within 24 hours affe To the Funerel Dir completely filled in	Medical		ner: On the basis of examin and manner stated.	ation and/or in	nvestigation, in	my opinion, o	death occurred	at the time,	date and pla	ace, and d	ue to the cause(s) onth, Day, Year)
			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type	Print)	27			4/1	6/07)
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 6 2007	32. Registrar's Sign	docute Coarle	5 Mai	c Aha.	I pal	Bel	Aw.	Mn.	21014

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** WALLACE 13:57 FRANCES APRIL 2 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CITY BALTIMORE THE JOHNS HOPKINS NONE HOSPITAL 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 F 214-32-9379 75 MARYLAND **Director** Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Tyes 2 No Director MARYLAND CHARLES INDTAN HEAD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 100 ELLERBE DRIVE 20640 UNITED STATES Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 □ Yes 2 No altimore, Maryland 21215-0036 Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) RETIRED MAIL CLERK FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (JOHN PHILLIP SMOOT LOUISE JACKSON SMOOT Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) If Item 27 RAYMOND WALLACE, SR./ HUSBAND 100 ELLERBE DRIVE, INDIAN HEAD, MARYLAND other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important; If It any Injury or conce. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. CHARLES CEMETERY APRIL 17,2007 GLYMONT, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liensee Land Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAYS Physician Due to (or an a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injuly that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ed by the a detached f 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signe I be o Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA ۲ 27. Manner of Death 1. Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

Neral Director: A
filled in by the fu 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-DOD AMY RUHL, MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE AMY RUHL, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 1 6 2007

			1 - For State Registrar	State of	Marylan		artmen rtificate			and M		giene Reg. No	6001	137	17
	Physici	an	Decedent's Name (First, Middle,								2. Date of De	ath 11	y 2007	3. Time of De	
	/Medic	al	LELIA AUG 4a. Facility Name (If not institution,		LLIAMS	-	4b City	Town or	Location o	of Death	ALKIL		. County of Dear	7:30	Рм
	Examin	ier		SS HOSPIT					ER SI		7			GOME RY	
	Funeral Director	71	5. Social Security Number 240–48–7731	.Sex 7. 1 □ M 2 🗓 F	_	last birthday)	If Under Months		If Under a		8. Date of Bir (Month, Da JULY	th Iv Year, 15,	9. Bird 1933	hplace (State or Fountry) NORT CAROLINA	oreign H
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City I	Limits
	he Maryli 28a-f sho ciffied a	Director	NORTH	URHAM			DUR					10- 0	***** 6 145 - 1 C	1 🛣 es 2	
	Ba or	ī	2310 NEBO STR	EET			10f. Zip		706			iog. Ci	tizen of What Co UNITED	•	
36	d within 72 hours after deeth with the Maryland jiens - r then "naturel", or Iteme 23a or 28a-f show The Madical Examinat must be notified at	y Funeral	11. Marital Status 1 Never Married 2 Married	tf Yes, Give	es? [XNo		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto I	ecify Yes or No Rican, etc.))-	14. Race - Ame Black, Whit		CAN
Ş	furel,	ed by	3 Widowed 4 Divorced 15. Decedent's	Year or Date	os:	16a Dece	dent's Usua	l Occupa	ation			16h k	(ind of Business		
<u>ج</u> ج	nin 72 n na	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)	or 5 . \	(Give	kind of wor DO NOT us	k oone d e retired	furing most	t of workii	ng	100.1	EDUCA'		
7	giene grene er the	Com	12	College (1-4	UI 5+)		TE	ACHE	R				EDUCA	11011	
Maryland 21215-0036	should be filed nd Mental Hygis marked other umatic event, III	To Be (17. Father's Name (First, Middle, La HERBERT TH	•	AMS					r's Name VASH	(First, Middle TI Mi		Sumame) INER		
	nd 2 lith a 27 is		19a. Informant's Name/Relationship GLENDA MITCHIN		COUSIN	5.00	ng Address 1204 I	(Street a EAST	SIDE	or or Rura DRI	VE, GRI	er, City EENS	or Town, State, 2 BORO, N	Zip Code) C 27406	
altimore,	@ Q b-		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ate BE	Place of Disponentary cre ECHWOO	osition (Nam matory or of D CEME	ne of ther plac ETER	e) A	PRIL	18, 2007	20c, L D NOR	ocation - City or URHAM TH CAROI	Town, State	
Balt	permit. Page Depertment Important: If eny Injury or		21. Signature of Funeral Service Li	censee of	n#	993 3	FISHEF DURHAN	d Addres FUI 1, NO	s of Facilit NERAL ORTH	y PAR CARO	LOR LINA				
8760,	death certificate be executed Example of ettending physicien and dor use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or consock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CAI Due to (or Due to (or	RDIOPU as a conseq	LMONAR uence of): LMONAR uence of):	Y AR	REST		cardiac o	гезрігатогу а	mest,	- U	Approximate Interval Betwee Onset and Dea	
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1	uires that n signed b ld be deta	Ď	Part II. Other significant condition	s contributing to deat	h but not res	ulting in the u	inderlying ca	ause give	en in Part I.					the cause of dea	
Vital Records,	sician: The law requires that the certificate has been signed by thirector, page 2 should be detache	Completed									24a. Was auto perfo 1 🗆 Yes		prior to death?	utopsy findings ava comptetion of cause 2 No	ailable se of
	siclar certificacto	o Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	Hospital: 1 🛣 Inp	ationt 2	ER/Outpatie	nt 3□ DO	Othe			Check only		6 □Other (Spe	-4.1	
Ö	g Physical dispersal di	n: To	27. Manner of Death	28a. Date of (Month,		28b. Time o		8c. Injury Work	at		28d. Describe			спу)	
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Division of	or fiter	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of	Injury · At h , etc. <i>(Specil</i>	ome, farm, st	reet, factory	, office			28f. Location (City or To			ural Route Numbe	or,
	Hospitel 24 hours a Funerel i letely filled	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the be aminer: On the basi	s of examina	owledge, deat ition and/or in	h occurred a	at the tim	ne, date and pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s	s) and manner a d place, and due	s stated. e to the cause(s)	
	To the Hosi within 24 ho To the Func completely f	Med	29b. Signature and title of certifier	and manner	stated.		29c	. License	number			29d. Da	ate signed (Mont	th, Day, Year)	
	F 3 F 8		Sointo	2/10			1) mn	650	fa			-	13, 2007	
9	N2		30. Name and address of person was SIRAK LEMMA,	M.D.	of death (Iter	n 23a) (Type, 500 FO	Print)				LVER S	PRIN	G, MD	20910	
	Sta Registr		31. Date filed (Month, Day, Year) APR 1	2007 32. FB 9	istrar's Signa	ature	bost	,							

DHMH 17 Rev 1/2001

			For State Registrar		State of M	1arylan	-	artment ertificate			and Me		ene ₂	007	13718
-	Dhuniai		Decedent's Name (First, Middle, Last) One of Deat Month										Day	Year	3. Time of Death
	Physici /Medio	_		Fredia		War	mpler-M	oney					8, 20		10:47a _M
7	Examir	er	4a. Facility Name (If no	ot institution, giv	e street and numbe	r)		4b. City, T	own, or	Location of	of Death		4c. Cou	inty of Deat	h
	1.6.00		7102 Mast							Market			Fre	ederick	
Ш	Funeral		5. Social Security Numb		Sex 7.4 1 □ M 2 🔼 F	ige (In yrs.	last birthday		Days Days	If Under Hours	Min. 8	B. Date of Birth (Month, Day,	Year)	9. Birt Co	hplace (State or Foreign untry)
l.	Director		217-42-0643			62	Yrs.				A	pril 15,	15, 1944 Pennsylvani		
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	sho	Į.													1 ☐ Yes 2 X No
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	with a or	ij	10e. Street and Numbe	er .				10f. Zip (Jode			"	y. Chizen	or wriat Co	unity:
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral	7102 Maste	ers Road	12. Was Deceder	t Ever in II	C 12	Man Donado	217		igin?/Cana	ifu Van ar Na	14.1	U.S.A.	rican Indian,
	ltem ner r	ů	11. Marital Status	ON Marriad	Armed Forces	?	.5.	If Yes, speci	fy Cubar	n, Mexicai	n, Puerto R	ify Yes or No- ican, etc.)		Black, White	
36	rs aft	by F	1 ☐ Never Married 3 ☐ Widowed 4 ☐		If Yes, Give Year or Dates			1 ☐ Yes 2	X No	Specify:			Spe	ecify:	White
21215-0036	houn tural	pe		5. Decedent's E			16a Dece	edent's Usual	Occupa	ition		1	6h Kind o	f Business/	
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	be filed within 72 hours after death with the Marylar tat Hygiene. do other than "natural", or ftems 23a or 28a-f show other than "natural", or ftems to notified at event, the Medical Examiner must be notified at		17. Father's Name (First	st, Middle, Last							er's Name ((First, Middle, M			
an	d be ental ked c	To Be	Fred	1 Eugene	Wampler					м	lary Lo	u Ilnaec	ertair	ahla	
Maryland	ages 1 and 2 should be filed with of Health and Mental Hygie: If Item 27 is marked other too other traumatic event, the	F	19a. Informant's Name				19b. Mail	ling Address (Street a			Route Number,			Zip Code)
Ma	id 2 sth ar				- Daughter							k, Maryla			, ,
á,	1 ar Hea tem 2		20a. Method of Disposit		Daugnter	20b. F	Place of Disp	osition (Name	e of	1	Da	-			Town, State
ē	Pages nent of h ant: If Ite				Removal from Stat	e Par	klawn N	ematory or oth demorial	herplace Park	c & 1	. /20/0	007	D		
Baltimore,	permit. Page Department Important: If any Injury o		4 □ Donation 5 [21. Signature of Funer		-	Me	enorah (Gardens 22. Name and	Addres		4/12/2	007	KOCKVI	.IIe, M	aryland
Ba	permit. F Departme Importan any Injur		21. Signature of Furier	a salvice lice	risee		I	lines-Ri	na1di	i Fune	ral Ho	me, Inc.			
			OD- David Strain	7//08										ng, Ma	ryland 20904
Fiz.				ailure. List only	one cause on each	line.							SI,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)		Due to (or a		. ,			11.	1-ct				,
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oro	w require been signal	ted	-									1 XYe	5 Z N		ODADIY 4 DOTIKIOWII
Records,	e law has be	Completed										24a. Was an		4b. Were au	topsy findings available completion of cause of
H		, or										perform	ied? No	death? 1 ☐ Yes	_
or Vital	Physician: The this certificate har all director, page	Be (25. Was case referred examiner?	I to medical						26. Place	of Death	(Check only one)		
7	Physic this ce al dire	2	1 Yes 2 No		Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatie	ent 3 DOA	Othe	er: 4□ Nu	ursing Hom	e 5 Reside	nce 6 🗆	Other (Spe	cify)
	ding Ph T. After th funeral		27. Manner of Death 1 Avatural	5 ☐ Pending	28a. Date of Ir (Month, L	njury Day Year)	28b. Time Injury	of 28	Bc. Injury Work	at ?	28	Bd. Describe ho	w injury oc	curred	
<u>.</u>	Attending r death. ector: After by the funer	atic	2 Accident	investigatio	n	, ,		М		∕es 2□	No				
Division	er de recto	tific	3 ☐ Suicide 6 4 ☐ Homicide	6 Could not be determined	28e. Place of I	njury - At he etc. <i>(Specil</i>	ome, farm, s	treet, factory,	office		28	Bf. Location (Str. City or Town,		umber or Ru	ıral Route Number,
Ö	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Certification:		-	3,	, ,									
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	Veith Common of the transfer o	Σ	29b. Signature and title	e of certifier						number		29	d. Date si	gned (Mont	h, Day, Year)
	17/		MIN	hal L	erner	M.	0		D	1161	4	- (4pri	1(11,	2007
	1		30. Name and address	s of person who	completed cause o	death (Iter	n 23a) (Type	e, Print)	-		<u></u>		-		
			Michael Ler	rner, M.D	., 63 Thomas	Johns	son Driv	ve, Suit	еE,	Frede	rick,	Maryland	21702		
1.	Sta	ite	31. Date filed (Month,		Attitud	strar's Signa	ature	al.							
	Regist	rar	APA	? 13 20	U/	es la	F GO	anti-							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** LAURA YOUNG 04 10 2007 10:11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner **KESWICK MULTI-CARE CENTER** BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 F Yrs. Director PHILADELPHIA, 198-10-7961 10-21-1911 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c City Town or Location 10a State 10b. County r 28a-f show 1 XYes 2 □ No MD BALTIMORE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code , or items 23s or 26 STOCKMILL ROAD, APARTMENT G 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. illed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK ð 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d other then svent, the Mex College (1-4or 5+) Elementary/Secondary (0-12) INSURANCE PROCESSOR VETERAN'S ADMIN. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked THOMAS THRIFT MARY DAISY HARRISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANIS DAWKINS/DAUGHTER 1412 GRAYS FERRY AVENUE, PHILADELPHIA, PA 19143 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State EDENS CEMETERY 4-16-2007 4 ☐ Donation 5 ☐ Other (Specify) COLLINGDALE, PA 22. Name and Addre MARSHALL'S FUNERAL HOME OF MD, INC. 21. Signatue of Funeral Service Lin 4308 SUITLAND RD, SUITLAND, MD 20746 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sirick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENDSTAGE **Physician** ers /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts.) Dua to (or as a consequence of). attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ۵ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide ō within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ş 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) FaulknermD/6565N. Charles Street 32. Registrar's Signature State Registrar

			4 101	epartment of Health and M Certificate of Death		ene 0 0 7	13720
	Dhuniai		Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Miguel R. Za	rate	April 8,		10:30 A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Joseph Richey Hospice	Baltimore			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 577−78−7459 12 M 2 □ F 83 Yr.	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y) Sept 28,	(ear) 9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	15.	Sept 28,	1923 N	lexico
	land ow		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	Mary 	ğ	Maryland Prince George's	Bowie			1 XYes 2 No
	the 7.28a	<u>5</u>	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?
	h with	by Funeral Director	13333 Idlewild Drive	20715		Mexico)
	deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - Ameri	
ထ္	or Ite	F	1 Never Married 2 Married 1 Yes 2 No	1 XVac 2 No Specific		Black, White	, etc.
8	ure!;	d b	3 Wildowed 4 Divorced Year or Dates:	Mexi	.can	Specify: W	hite
7	net "net	Completed	(Specify only highest grade completed) (Decedent's Usual Occupation Give kind of work done during most of worki life. DO NOT use retired)	ng 16	b. Kind of Business/Ir	ndustry
2	withir ene. then	μď	Elementary/Secondary (0-12) College (1-4or 5+)			D	
9	filed Hygi other	ပို	17. Father's Name (First, Middle, Last)	nstruction Worker 18. Mother's Name	(First, Middle, Ma	Private	
Maryland 21215-0036	ld be ental ked c	To Be	Zeferino Zarate		goria Ros		
E S	shound M	-	19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Number or Rura			o Code)
Ž	alth a		Ana Zarate (Wife) 13	333 Idlewild Drive,	Bowie MD	20715	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "neturel", or Iteme 23a or 28a-f ehow eny Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of E	Disposition (Name of Crematory or other place)	ate 20	c. Location - City or T	own, State
Ĕ	Page ment ant: H	-	I La Dullai & Cientation 3 Chellioval Ilom State	ncoln Cemetery 4/13/	2007 B ₁	rentwood,	Marvland
<u>=</u>	permit. Departr Imports eny Inj once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ren	don/Hale	Funeral H	ome .
<u> </u>	70 F 9 9		Hillicia Valencre	9013 Annapolis Road			
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.		r respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	son's disease			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			V
	1	-	Sequentially list conditions, if a. y, leading to immediate cause. Enter Underlying				
	ted nsit	nine	Cause (Disease or injury	·			
<u>,</u>	execu n and ial-tra	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
760,	ires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit	call	d.				
89	tifical og phy as th	=					
ŏ	th cer endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of deliv	
		sicia	1 Yes 2 No	5 Other (specify)		Month	Day Year
<u>a.</u>	d by t	by Physician/Med	9 Unknown				
S,	Attending Physician: The law requires that the rideath in death in death ector. After this certificete hes been signed by the thneral director, page 2 should be detached.		Part II. Other significant conditions contributing to death but not resulting in the Aucholism	ne underlying cause given in Part I.		co use contribute to t	ne cause or death?
Ö	w require been sig should t	etec	7 (000.00.)		100 165	20140 301110	Dably 4 Officional
Records,	e law hest	Completed			24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of
a	ician: Th certificete rector, pag				1 Yes 2 ⊡	No 1 ☐ Yes	2 □ No
₹	ysicien: The lar is certificete hes director, page 2	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	26. Place of Death		2 To 12	. har in
Division of Vital	g Phys er this eral dii	n: To	27. Manner of Death 28a. Date of Injury 28b. Tin	ne of 28c. Injury at 2	28d. Describe how	injury occurred	y) hopice
<u>o</u>	ath. r: Aft	atio	1 ☑Natural 5 ☐ Pending (Month, Day Year) Inju 2 ☐ Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No			
N N	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Run	al Route Number,
ā	rs afte	Cer	building, sto. (opeally)		Ony or 10mm, c	, all of	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th gompletely filled in by the funeral		29a. Certifier (Check only (Ch	death occurred at the time, date and place, a	and due to the caus	se(s) and manner as s	stated.
	To the Vithin 2 To the Complet	Medical	one) and manner stated. 29b. Signature and title of certifier.	29c. License number			
	F 3 F 8		() Lynn	D 5621	290.	Date signed (Month,	Day, 1 Gai)
	(4)		30. Name and address of person who completed cause of death (Item 23a) (Ty			1/3/0/	
لأي	C			tanor St. Baltin	nore MD	21225	
	Sta		31. Date filed (Month, Day, Year) APK 132000 32. Registrar's Signature		/1.~	.~~~	
	Registr	ar	MINI LO COUT Street 10. Specker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 13721

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23b. Was decedent pregnant in the past 12 months? 1	
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2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Rout or Town, State)	
Q 3 2 2 3 4 Homicide determined (Specify)	Number, City
	s)
Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,	
Les Seghio O.C.M.E. April 25, 2007	
30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar APP 3 0 2001	

ORIGINAL

			For State Registrar	State of Ma	ryland		artment of rtificate of			-	gienę Reg. No	2111	7 [:	3722
	Physici /Medic	- 1	Decedent's Name (First, Middle, Last ALMA BAKER	st)						2. Date of De Month 4 – 25 –	Day		r	ne of Death
	Examir	20	4a. Facility Name (If not institution, give	e street and number)			4b. City, Town,	or Locatio	n of Death		4c.	County of De		
			CLEN BURNIE HE				GLEN If Under 1 Yea		NIE er 24 Hrs.	R Data of Bir		NNE A		
Р	Funeral Director		5. Social Security Number 6. S 1 241 – 36 – 6294	ex / Age □M 2√F / Age	(In yrs. las	Yrs.	Months Days			8. Date of Bir (Month, Da	y, Year)		Country)	ate or Foreign
			Usual Residence of Decedent							8/04/	192	8	NC	
	how at		10a. State 10b. County	13	10c. City, 7									de City Limits
	e Ma 3a-f s tified	cto	MD N	/A	BF	4Τ.Τ.Τ <i>1</i>	MORE CI	'I'Y						Yes 2□No
	or 24	Dire	10e. Street and Number	D. T. I. I.			10f. Zip Code				0	zen of What	Country?	
	s 23a	eral	2877 BOOKERT D	12. Was Decedent E	vor in II S	12		225	Origin 2 /Cr	posify Voc or No		SA 14. Race - Ar	nerican India	n
	ter de	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		13.	Was Decedent of If Yes, specify Cu	ban, Mexi	can, Puerto	o Rican, etc.)	-	Black, W		,
036	urs af	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1□Yes 2∏ No	Speci	fy:			Specify: B	LACK	
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	ted	15. Decedent's Ed (Specify only highest gra	lucation		16a. Dece	dent's Usual Occi	upation	ost of work	kina	16b. Ki	nd of Busines	s/Industry	
21	within ene. than " he M·c	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. CI	kind of work don DO NOT use retir LERK	ed)		9	US	SOC	SEC	ADMN.
121	be filed within 72 hours after death with the Marylan tital Hygiene. ed other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the M-dical Examiner must be notified at		8 17. Father's Name (<i>First, Middle, Last,</i>					18 Mo	ther's Nam	ne (First, Middle			020.	
Maryland	should be filed and Mental Hygi marked other matic event, t) Be	HERBERT CAMPB								771030077	ourname)		
<u> </u>	and Men is marke	ပ္	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Stree			DAVIS ral Route Numb	er, City o	r Town, State	, Zip Code)	
S	nd 2 ulth a 27 ls		HELEN B MUNDEL	L/DAUGHTI	ER	5539	CHANN	ING	RD,	BALTIM	ORE	, MD	21229	
J.	ges 1 an t of Heal ff item 2 or other		20a. Method of Disposition	1D	20b. Plac	ce of Dispo	esition (Name of matory or other pi DRE NAT CTERY	ace)		Date		cation - City		
<u>=</u>	Pages nent of I ant: If its ury or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		AŞ	CEWE	ETERY NAT	L	5/1	/07	BA	LTIMO:	RE, M	D
Baltimor	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Licer	isee X			2. Name and Add							
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	ROI	0-1	RESPI	1219	7012	4 F19	1/6	IRE		
1	Examiner			Due to (or as a	conseque	nce or):	IN GAN	1 F	AIC	URG	-			
	لتبلا	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	conseque	nce of):	7- 0//	•						
	cuted nd ramsit	Examiner	that initiated events		653		IF HE	3191	27	FA10	MI	26		
, 0	ite be executed sysician and he burial-transit		resulting in death) Last	Due to (or as a			KIDN	154	7	-4111	101	-		
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9 X	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, outcome p	of pregnanc	rv.						00 d D-t (-	1 - Pt	
Box	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal d	leath 3[Ectopic pregnan Other (specify)	су			,	23d. Date of o Month	Day	Year
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٦,	uires that signed b d be deta	by Pi	Part II. Other significant conditions	contributing to death bu	t not resulti	ing in the u	nderlying cause g	jiven in Pa	rt I.	23e. Did 1	obacco u	ise contribute	to the cause	e of death?
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m m	yslclan: The is certificate hadirector, page	Com	174 PG	NION	40,	1					rmed?	death 1 ☐ Y	?	
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Or \	Physician: r this certifica ral director, p	2	1 Yes 2 No	Hospital: 1 Inpatier		R/Outpatier	" OLI DOX		Nursing H	ome 5□ Resi			pecify)	
	ding Phy After thi funeral (ion:	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	Year)	Injury	W	uryat ork? ∐Yes 2	□No	28d. Describe	now injur	y occurred		
Division	I or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not b	e 28e. Place of inju	ry - At hom	e, farm, sti				28f. Location (Street an	d Number or	Rural Route	Number,
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	Viith Voir	Σ	29b. Signature and title of certifier	h door	16		29c. Lice	nse numbe	er		4 -	te signed (Mo		ear)
	2		CARLOS N. PA	TAUNGT	Tuo.	CR M	0 0	184	26	-	YKI	1-30,	2007	•
	("		30 Name and address of person who	completed cause of de	eath (Item 2	3a) (Type,	Print)	Tin	1002	- 116) -	130,		
	Sta	te.	31. Date filed (Month, Day, Year)	32 Registra	r's Signary	pe A	all)	11100	4100	1	4	115		
	Regist		APR 3 0 2	007 Heren	J. J.S.	14								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Donald Stuart Brewer 27, April 2007 6:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 219-18-7292 Director 80 Dec. 20, 1926 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4240 Chapel Road 21128 Funeral U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No Maryland 21215-0036 1 ☐ Yes 2 🛣 No ≥ Specify. Specify: 3 ☐ Widowed 4 🕅 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) 9 Owner Automotive Business Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George W. Brewer ပ္ Virgie V. Schooler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Brewer (Son) 5998 N. Main St., Rock Hall, Maryland 21661 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 05/01/2007 | Baltimore, Maryland Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KNOWN **Physician** Metasta ovimari /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and deeq betached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 icate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 No 1□ Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending investigation death. al or Attendi s after death. 1 ☐ Yes 2 ☐ No the i 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours aft

To the Funeral D

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Mahmood aney 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of ____and / Department of Health and Mental Hygiene Amend 18, perFH, g867, 5/1/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Physician Day Year MARY BYCHICH 26 2007 Prace 10:50 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis DALMANNE City BALMINIKE 17am, 1/m If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛱 F Yrs. Director 216-14-8911 83 July 13, Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mantal Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ñ Yes 2 No Funeral Director Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4035 Shannon Drive 21213 U. S. A. 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No Specify: Be Completed by Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) clerk Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lillian Margaret Leidt John Valentine Henry, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Katherine Whipp (Friend) 5630 Daybreak Terrace, Baltimore, Maryland 21206 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 4/30/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Schimunek Funeral Homes 9705 Belair Road, Baltimore, Maryland 21236 el 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Sepsis 2 weeks Examiner Due to (or as a consequence of): Examiner ettending physician and for use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be datached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Vementa þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s CUAIS 1 Yes 2₽No 1 ☐ Yes 2 ☐ No after death.

Director: After this cartific in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4₽ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completaly filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated.

The law requires thet the death certificate be axecuted Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica

has

After this cartificate

Baltimore, Maryland 21215-0036

State

Klu MO 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Wendy

KlocsE

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

6701 N Charles St 32. Registrar's Signature

Registrar DHMH 16 Rev 6/95

29c. License number

4202

D31250

Tows ~

29d. Date signed (Month, Day, Year) 7/27/67

21206

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Meri 13:50 seve 2001 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death City, Town, or Location of Death Examiner If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** 5. Social Security Number 8. Date of Birth (Month, Day, (State or Foreign Year) 6 855 Days Min 1 M 2 □ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 700 Director MO 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Cumberland MA Dr 21502 USA 12816 nurmel Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than. Elementary/Secondary (0-12) College (1-4or 5+) EACHER the education is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be €1005€ LORA ျ ILLLIAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trainonce. 12816 Thurmel Drive Cumberland, MD 21502 Sally Buser/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade 22 Name and Address of Facility State Anatomy Board 655 W. Baltimroe Street 3a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, it heart failure. List only one cause on each line. nn Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mbuutea /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tra a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 TYes To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of 28c. injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours after death the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 544 11 30. Name and address of pe on who completed cause of death (Item 23a) (Type, Print) AUE 500 UMBERLAND MU

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year.

APR 3 0

32 Registrar's Signature

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Angela Florence		ursey Sta 1- For State Registrar	ate of Maryla	and / Departm <i>Certifi</i> d	nent of cate of i		d Menta	al Hygi		eg. No.	20	07	10	72
Physicia Medical Exami	an/	Decedent's Name (First, Middle Angela Florence)	•	7				1 N	Date of Deat Month pril 23, 2	Day	Year		Time of De	
·		4a. Facility Name (if not institution 1 West Conway Street	n, give street and nu		41	o. City, Town, or Baltimore	Location of	Death		4c. (County of D	eath		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. last bi	•	If Under 1 Year Months Days		Min	Date of Bir		Fo		oce (State	
япу		227–45–7578 Usual Residence of Decedent 10a. State 10b. County	I M Z AF	10c. City, Tow	Yrs.	n	1	l	03/08	/ 198	.0		'Caro.	
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th the Maryland 23a or 28a-f sho	Director	10e. Street and Number 1 West Conway	Street #3	311		10f. Zip Code 21201					en of What	·		
death with r items 27	Funeral	11. Marital Status		cedent Ever in U.S.		Decedent of His s, specify Cuban			y Yes or No		4. Race - A White, e	merican		ick,
HITS after (itural", o	3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use refired)										pecify: W			
15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)									on					
Student Student 17. Father's Name (First, Middle, Last) David James Coursey Student 18. Mother's Name (First, Middle, Maiden Sumame) Susan Karen Weaver									OH					
The property of the property o											.,			
David James Coursey - Father 7103 Pinecrest Road Baltimore, Maryland 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Cathedral Cemetery Cate 20c. Location - City or crematory or other place) 4 Donation 5 Other Specify New Cathedral Cemetery 04/27/2007 Baltimore, Maryland 20b. Place of Disposition (Name of cemetery or other place) 1 X Burial 2 Cremation 3 Removal from State Cathedral Cemetery 04/27/2007 Baltimore, Maryland 20b. Place of Disposition (Name of cemetery or other place) 20c. Location - City or crematory or other place 20c. Location - City or crematory or other place 20c. Location - City or crematory or other place 20c. Location - City or crematory or other place 20c. Location - City or crematory or crematory or crematory or crematory or crematory or crematory or										ty or Tov	vn, State			
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យ «៩៩.៩ Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that o	caused the death. Do	i 531	1 Edmon	dson	Avenu	e Bal	timo	re. M	1 /	and and approximate Between O	e Interval
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Seizure	e disorder					_			-	Dea	
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Box 68760, c death certificate be execution the attending physician and effor use as the burial - tra	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live I	birth	у	il death 3	Ectopic	pregnancy			Date of del Month	ivery Day	,	Year
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Division of Vital Records, P.O. Box 68760, the Hospita or Attending Physician: The law requires that the death certificate be hin 24 burstal Director: After this certificate has been signed by the attending physici nipletely filled in by the funeral director, page 2 should be detached for use as the buri	Completed							- [24a. Was autop perfor 1 Yes	sy rmed?	prior deat	r to com	sy findings pletion of c 2	ause of
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of Vital ng Physician: After this certi	၀	examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2 ER/0	Outpatient	3 DOA	Other ₄	Nursing Ho	ome 5	Residen	ce 6 🗸 C	Other: So	ene	
Sion of Virture of Mirate of the signal of t	tion: T	27. Manner of Death 1 X Natural 5 Pend	ling	of Injury 28b n, Day,Year)	. Time of Inj		ry at Work? /es 2 1	i	l. Describe I	how injur	y occurred			
Division ospital or Attendir hours after death.	Certification:	3 Suicide 6 Coul	d not be mined (Specify)	ce of Injury - At home,	farm, street	, factory, office b	uilding, etc.	. 28f.	Location (S or Town, S		d Number o	r Rural	Route Num	ber, City
So the state of th									ause(s)					

30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. 31. Date filed (Month, Day, Year) APR 3 0 2007 State

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 24, 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Dec t's Name (First, Middle, Last) **Physician** 26 2007 /Medical 4c. County of Death Town, or Location of Death titution, give street and number) Examiner N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 5. Social Security Number **Funeral** Min 1**X** M 2□F Days Hours Yrs. 216-18-9894 80 05/29/1926 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. Count "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE CATONSVILLE 10e. Street and Number 10g. Citizen of What Country? 16 FUSTING ROAD 21228 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Agned Forces?

1 Yes 2 Now If Yes, Give WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: WHITE Specify Completed by 3 Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) MARYLAND DEPARTMENT (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than " any injury or other traumatic event, the Mex any injury or other traumatic event, the Mex ones. Elementary/Secondary (0-12) College (1-4or 5+) OF TRANSPORTATION SUPERVISOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CONN MARGARET UNKNOWN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ELISA CONN / DAUGHTER 4141 TRUMP ROAD, WESTMINSTER, MD Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition MOSE'S MONTEF (ORE WOODMOOR HEBREW 1 ☐ Burial 2 ☐ Cremation 5 ☐ Other (Speqify) 4 Donation 04/27/2007 | BALTIMORE, 22. Name and Address of Facility SOL LEVINSON & BROS., INC. f Funeral Service L 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, caused line. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) **Physician** 10000 /Medical le to (r is a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner be executed burial-trar and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months
1 Yes 20 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknow þ signed to 23e. Did tobacco use contribute to the cause of death? cant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 ☐ Yes 2 ☐ No perforn Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ို 1 Yes 2 N 1 Impatient 2 ER/Outpatient 3 DOA After this . Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 16 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 32. Registrar's Signature State 2007 Registrar

			1 - For State Registrar		State of	Marylano	•	artment of F rtificate of		Mental H	Reg. No.	007	1010
			1. Decedent's Name (First, M.	ddle, Las	st)					2. Date of D			3. Time of Death
	Physici /Medio		Elizabeth T	. Du	pre					Apri	1 24,	2007	1:20 PM M
	Examin		4a. Facility Name (If not institu		•	ber)		4b. City, Town, o	r Location of Dea	ath	4c. C	County of Death	
			Goodwill Nu	rsin	g Home			Grants	ville		0	Garrett	
	Funeral		5. Social Security Number	6. S		. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of B	irth (ay, Year)	9. Birth	place (State or Foreign
	Director		273-20-5703 Usual Residence of Decedent		□M 2∏F	85	Yrs.	Months Days	Hours Mir	Oct 25		1 Mary	land
	land ow		10a. State 10b. Cou			10c. City,	Town or Lo	cation			•		10d. Inside City Limits
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21215-0036	within 72 hours after deeth with the Maryland jiene. r then "natural", or iteme 23a or 28e-f ehow tre Medical Examinar must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Never M		Armed Force 1 Yes 2 If Yes, Give Year or Dat	Ŋ No		If Yes, specify Cuba 1 ☐ Yes 2 X No	an', Mexican', Pue Specify:	irto Rican, etc.)		Black, White Specify: white	, etc. nite
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a	2 shoul and Me is mark		19a. Informant's Name/Relati	onship (7	Type, Print)		19b. Mailir	ng Address (Street	and Number or I	Rural Route Num	ber, City or	Town, State, Zi	p Code)
	and alth		Vladimir Dupr	e/sp	ouse		1362	Short Ru	ın Road	Kitzmil]	er, M	D 2153	8
Baltimore,	nit. Pages 1 and 2 should nertment of Health and Mer cortant; if item 27 is marke injury or other traumatic.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati 4 ☒ Donation 5 ☐ Othe			i con	ce of Dispo netery, crei	sition (Name of matory or other plac	ca)	Date	20c. Loc	ation - City or T	own, State
Balt	permit. Pages Depertment of importent; If I any injury or once.		21. Signature of Funeral Find ROD 1 d	ice Licen	Wade, i	rector	St	Name and Addre ate Anato ltimore,	omy Boar	d 655 W	. Balt	imore S	Street
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oʻ.	exec an an riai-tr	Еха	resulting in death) Last		Due to (or	r as a conseque	nce of):						
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68	ifficat g phy as th	edi											
.O. Box	The law requires that the death cer ste has been signed by the attendin bage 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown			th 2 ☐ Fetal d nt at time of dea	leath 3[Ectopic pregnancy Other (specify)	,		23	3d. Date of deliv Month	rery Day Year
Δ.	that led by deta		Part II. Other significant con-	ditions o	ontributing to dea	th but not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
ds	uires Isign Id be	d by	Huser	ipic	lemia					1	Yes 2K	No 3□Pro	bably 4 Unknown
Ö	w requir been si should I	ete	041.00	200	ecé c					24a. Wa	1	045 18/202	findings suppleble
Vital Records,		Completed	0.31 00	DEN (1012.					aut	opsy formed? 200 No	prior to codeath? 1 Yes	opsy findings available ompletion of cause of 2년 No
ŽĬ.	Physician: 1 this certificer ral director, p	Be	25. Was case referred to med examiner?	lical	Hospital:			! Oth	05	eath (Check only			
	Phys this	ျှ	1 ☐ Yes 2⊠No 27. Manner of Death		1 🗆 Ing		P/Outpatier		4 Danursing	Home 5 ☐ Res			fy)
Ĕ	De je je	on	1 ⊠Natural 5 ☐ Pe			Day Year)	8b. Time o Injury	Wor		28d. Describe	now injury	occurred	
Sic	Attending r death.	cat	E / 10010 0.11	estigation uld not be		41-1			Yes 2 □No	00(1	(01	Must	75
Division of	or A after Direction by	Certification:	4 ☐ Homicide det	ermined	building	g, etc. (Specify)	ie, farm, sti	eet, factory, office			own, State)	Number or Hur	al Route Number,
_	Hoepital		200 Continue 191 Conti	4.i Db	veleje – To No b					44			
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 1 Certi (Check only 2 Medi	cal Exan	ysician: To the bas niner: On the bas and manne	is of examinatio	n and/or in	n occurred at the tir vestigation, in my o	ne, uate and pla- pinion, death oc	curred at the time	e, date and p	olace, and due	to the cause(s)
	ithin o the	Me	29b. Signature and title of cer	tifier		or atarog.		29c. Licens	e number		29d. Date	signed (Month)	Day, Year)
	+ ≥ ⊢ ŏ		Xalaal	1	110	المامر		~	01 0	· c-	1.1	21,11	77.
7		1	20 Name and addition of	V	nompleted	of door ("	20n) /F		865	5		041	
			30. Name and address of per-	on who Naw					Croster	rilla Ma	214	536	
	Sta	to	31. Date filed (Month, Day, Yo			will Nu		5 none	Grants	rille,MD	21	730	
	Registi		APR 3 0	2007	A Core	1 De 1	Loose						

DHMH 17 Rev 1/2001

Registrar

200

Dameon Dubose		State of Maryland / Department of Health and Mental H -For State Certificate of Death		2007	13730
Physician		2. Date of Death	. No. 400 /	3. Time of Death	
Medical Examine		Dameon M. Dubose	Month April 22, 20	Day Ye≱r 07	2152 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Sinai Hospital Baltimore	1	4c. County of Death	
Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	8. Date of Birth	(MM/DD/YYYY 9. Bir	thplace (State or
Director	4	214-7-988 1X M 2 F 23 Yrs. Months Days Hours Min	112/29	1983 Foreig	untry) Mi
	- 1-	Usual Residence of Decedent			
ow any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 XYes 2 No
ryland a-f sh	흲	10e. Street and Number 10f. Zip Code	100	. Citizen of What Cour	
he Ma 1 or 28 iffed a	Director	3501 West Garaison Moorie 2015		$1 \leq \Delta$, .
with t		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S			can Indian, Black,
death or iter must	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	٠.
s after rral",	ᇗ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify:	ick
2 hour	<u>ا يو</u>	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		16b, Kind of Business/	Industry
within 72 hours after death with the Maryland giene. Net than "natural", or items 23a or 28a-f sher than "natural", he with a force with the motified at once the control of the control o	Completed	12th Clerk		Fast Fi	\sim
1215-0 be filed w ental Hygie rreet the M		17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Ma	aiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Information Name (Street and Numbe	va to	dias	7.01
~ 8 5 5 € 7	2	Geneva Falina Mather 13501 VI Garaisa	A NO	Political Property of Town, State	UN 21215
e, N. 1 and Health Health item	1	20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
altimore rmit. Pages 1 a partment of He pportant: If it		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Obligation of Other Specify:	30/2007	Bultim	vo Mi
por uny	1	21 gnature of F neral Septice Lic ns 2 22. Name and Address of Facil	Who Co	Greene	16616
	4	Vange C. Priese 55151 taltimore	Nut I t	ke baltim	ve MO
Physician /Medical	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arres	st, snoo, or neart	Approximate Interval Between Onset and Death
Examiner	-	Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):			Deatil
	.	Sequentially list conditions, b			
	┋	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
₽·¬ ;	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
		d		_	
te be execut	ledical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		Dod Date of deliver	
68761 certificate rding phy	Physician/M	35. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of delivery Month	y Day Year
Box (e death ce the attended for use	200	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)		1	
D. B t the d by the ached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
i, P.O. Box 6876 ries that the death certificate signed by the attending phy be detached for use as th	ο		1 Yes	2 🗸 No 3 Prol	oably 4 Unknown
of Vital Records, ng Physician: The law requir wher this certificate has been a menal director, page 2 should 1	Completed		24a. Was ar		topsy findings available completion of cause of
n of Vital Records ing Physician: The law requi After this certificate has been tuneral director, page 2 should	E		perform 1 ✓ Yes 2	ned? death?	
Sertific corting	8 8	25. Was case referred to medical examiner?			h
F Vit	<u> </u>	1 V Yes 2 No Inpatient 2 V ER/Outpatient 3 DOA Outlet 4 Nursin	•	esidence 6 Othe	r:
n of oding Ph. h. : After the funeral	<u></u>	27. Manner of Death 28a. Date of Injury (Menth Pay Pearl 1 Natural 5 Pending Apr 22, 2007 2120 hrs 1 Yes 2 ✓ No	Subject shot	w injury occurred	
Division ratendin rate of a the result.	<u> </u>	2 Accident Investigation 28e Place of Injury At home farm street factory office building etc.	28f. Location (St	reet and Number or Ru	iral Route Number, City
Div	Certification:	Suicide Could not be	or Town, Sta		
0 5	- 11	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
To Son	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
		Jahren O.C.M.E.		April 23, 2007	
		30. Name and address of person who completed cause of death (Item 23a)			
5		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
Stat Registra		31. Date filed (Month, Day, Year) APR 3 0 2007 32/Registrar's Signature			

		-	For State Registrar	ate of Maryla		irtment of He tificate of E			giene Reg. No. 🤈 🗍	07	13731
÷	Physicia	an l	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al	Jimmy Fields			4b. City, Town, or	Location of Death	April	24 2 4c. County	2007	5:20A M
	Examin	er	4a. Facility Name (If not institution, give street 4902 East Chase Str				e, Maryla	bne	N/A	OI Death	
	Funeral	42	5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	h	9. Birthp	lace (State or Foreign
	Director		219–76–5086 ^{1XM}	2□ F	48 Yrs.	Wichurs Days	Hours Will.	June 1			yland
	and www.		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits
	Maryl -f sho	tor	Maryland N/A	R	altimore						1 DXYes 2 □ No
	h the	Directo	10e. Street and Number		archiore	10f. Zip Code			10g. Citizen of		*
	23a cust be		4902 East Chase Str			21205			United		
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	1 □ Never Married 2 Married 1	/as Decedent Ever in rmed Forces? ☐ Yes 2 ☑ No Yes, Give		Was Decedent of His f Yes, specify Cubar I ☐ Yes 2√2 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americ ck, White, v: Ame	
5-0036	72 hours "natural" idical Exi	Completed b	3 ☐ Widowed 4 ☐ Divorced Ÿ 15. Decedent's Education (Specify only highest grade con	ear or Dates: n npleted)	16a. Deced	dent's Usual Occupa kind of work done d DO NOT use retired)	ition uring most of worki	ing	16b. Kind of B	usi nes s/lne	dustry
2	within iene. • than "	dmo	Elementary/Secondary (0-12)	ollege (1-4or 5+)		et Metal	_		Plumbi	na &	Heating
N D	i filed I Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,			<u> </u>
<u>a</u>		To B	Golden Fields				Martha	Ham	monds		
Maryland	au ar		19a. Informant's Name/Relationship (Type. F	Print)		ng Address (Street a					
	l and lealth		Debra Fields-Wife	lan		East Chas		, Balti	more, M		
Baltimore,	0 0		20a. Method of Disposition 1★Burial 2 ☐ Cremation 3 ☐ Remo	vai from State		sition (Name of natory or other place	1				
	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	100	22	Cemetery Name and Addres	4/28, s of Facility			ore,	Maryland
ñ	permit. Departi Importi any inj			ber CFS	SP Da	vid J. We	ber Funer	ral Hom	es, PA	Mara	1201C Back
	,		23a. Part1. Enter the disease, or complication shock, or leaf failure. List only one call immediate Cause (Final)	ns that caused the d	eath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory a	rrest,	Man Y	Approximate Interval Between
	Physician		disease or condition	helest	alte	COLON	canco			2	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con-	sequence of):						0
		-	Sequentially list conditions, b. —	Due to or as a con-	se uence of:					-	
T	uted J Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	ficate be executed physician and s the burial-transit	Еха	resulting in death) Last	Due to (or as a con-	sequence of):						^
68760	ate be nysicia he bu	edical	d								
_		Med	IF FEMALE:								
P.O. Box	The law requires that the death certif tte has been signed by the attending bage 2 should be detached for use as	Physician/M	in the past 12 months?	yes, outcome pf pre Live birth 2 F Pregnant at time Unknown	etal death 3	Ectopic pregnancy Other (specify)				ate of delive	ery Day Year
ď.	ires that signed b	by Pł	Part II. Other significant conditions contribu	ting to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did t	tobacco use con	tribute to t	he cause of death?
ğ	w require been sig should b							10	Yes 2₩No	3 ☐ Prol	bably 4 □Unknown
Vital Records,	The law rate has be	Completed						24a. Was auto perfo 1□ Yes		Were auto prior to co death? 1 \(\text{Yes} \)	opsy findings available impletion of cause of 2 reproduced to the control of the cause of the control of the cause of the
/ita	i lclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	tal		Louis	26. Place of Deatl	h (Check only o	one)		
	ing Physi After this c funeral dir	7.	1 Yes 2 No Hosp 27. Manner of Death 2	1 ☐ Inpatient :	2 ER/Outpatie		4 LI Nursing Ho		idence 6 Ot		fy)
OUO	Attending Physician: r death. ector: After this certifics by the funeral director, p	tion	1 ≅ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea		Work	Yat (? Yes 2∐No	20d. Describe	now injury occu	neu	
Division or	l or Atten after deat Director:	Certification:	all publisher 6 Could not be	Be. Place of injury - A building, etc. (Sp	At home, farm, st ecify)	reet, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Run	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 → Certifying Physicia (Check only one)								
	To th withir To th comp	Me	29b. Signature and title of certifier	2 . 0		29c. License	number		29d. Date sign	ed (Month,	Day, Year)
			In Surtell &	Left Physe	ciap	D19	714		4/24/0	7	
	3		30. Name and address of person who compl	eted cause of death	(Item 23a) (Type,	Print)	Ala Ri	. =	0.0	-122	(/
	Sta	ate.	MILYARL PURTEIL (31. Date filed (Month, Day, Year)	32. Pegistrar's S	ignature	ZAIJONY,	AVE ()A	LIMOR	ind	-1 UL	7
	Regist		APR 3 0 2007	Bren	B. A	mark!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lon Scott Freedman State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Deat Physician/ Month Day April 23, 2007 Scott Freedman 0640 hrs Lon Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Toddsbury Lane Olney Montgomery 3508 Toddsburg Lane 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral oreign Months Days irectorڈ 1/23/1954 CountrWash. DC 53 219-64-2918 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location à 10a. State 10b. County 1 X Yes 2 No 28a-f show MD 01ney Montgomery Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20832 United States 3508 Toddsbury Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes White If Yes, Give Year Yes 2 X No specify: Widowed 4 X Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Complet Sales Manager 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norman Freedman Florence Levussove æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 1111 University Blvd West #708 Silver Spring $_20902$ Norman Freedman - Father 20c. Location - City or Town, State Date 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 XCremation 3 X Removal from State 4/30/07 Falls Church, VA National Crematory Other Specify Donation 5 21. Signature of Fun Service License Banzansky®Göldberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. /Medical Death a. Gastrointestinal Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Chronic Alcoholism Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and sician/Medical 4a per me g867 5-2-07 vt AMENDED UNPENDED attending physician for use as the burial The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of Other (Specify) Yes 2 No 9 Unknown ď 9 n signed by the a d be detached fo Unknown Phys 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed s certificate has been signector, page 2 should by 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 N No 25. Was case referred to medical 26 Place of Death (Check only one) To the Hospital or Attending Physician: Be Other₄ examiner? Hospital: Nursing Home 5 Residence 6 V Other: Scene 2 ER/Outpatient 3 After this Inpatient ို 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: within 24 hours after death.

To the Funeral Director; A completely filled in by the fun 1 V Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. April 24, 2007 Name and a ress of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

32. Refestrar's Signature

ORIGINAL

Registrar

31. Date filed (Month, Day, Year)

Registrar

State

31. Date filed (Month,

32. Registrar's Signature

A property

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Yea **Physician** 9:10 A Trebe 2007 4 nna /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Oak Crest Care Center Prkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs. 102 July 28, 1904 Germany Director 213-74-9567 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. inside City Limits 10a. State 10c. City, Town or Location 1 □Yes 2 No Directo Parkville Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U. S. A. 21234 8830 Walther Boulevard Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced White Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store 8 Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilhelmina (unknown) Wilhelm Kranz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4651 South Atlantic Ave., Unit 9604, Ponce Inlet, FL. William H. Grebe (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/28/2007 Baltimore, Maryland 4 Donation 5 Other (Specify) St. Michael's Luth.Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** eritoneo disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** or as Counsequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown þ Completed Be J₀ Certification: After t To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

Division or Vital Records, P.O. Box 68760,

Part II. Other significant conditions	contributing to death but not resul	Iting in the underlying	cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ Inknown
310				24a. Was an autopsy performed	
25. Was case referred to medical			26. Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 ☐ □	OOA Other: 4 Nursing H	lome 5 Residenc	e 6 □Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred
3 ☐ Suicide 6 ☐ Could not determine			ry, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, state)
	Physician: To the best of my know aminer: On the basis of examinat				se(s) and manner as stated. e and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

2007

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walther Boulevard, Baltimore, Maryland 21234 8832 Etosha Dixon,

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760 To the Hospital or mineral within 24 hours efter death.

To the Funeral Director: Aff

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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APR 3 0 2007

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1al ther

32. Registrar's Signature

Boulevard

1586

29d. Date signed (Month. Day, Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 23a, Pt 1, II, 25 Pet in 2009 07/20/07dhb Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22, 2007 Physician Month Wayne L. Graham 7:42 PM April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Yrs 213-28-9367 73 Director Mar 19, 1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2√ No Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 Bay Dale Drive 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other tha any injury or other traumatic event, the I once. 12 0 <u>electrician</u> U.S. Naval Academy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Sowers Graham Ida Virginia Lewis ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Graham/spouse 311 Bay Dale Drive Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, MĎ erry 23a. P. 11. Enter the discase, or complications that caused the death. shirth, or heart failure. List only one cause on partitions. Do not enter the mode of dying, such as cardiac or respiratory arrest **Cervical Stenosis with Advanced** Approximate Interval Between Onset and Death Immediate ause (Final disease or c n on resulting in death Spondylosis and Kyphosis **Physician** /Medical Due to (or as a consequent e of) with complications Examiner to other Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER and burial-trar Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>6</u> 2 No 3 Probabiy 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Mô 24a. Was an autopsy Vital 1☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Division or 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To unc within 24 hours a... To the Funeral Director '-⁴alv filled in by th 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

APR 3 0 2007

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

9 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	State Registrar			Certific	ate of	Death	7		Reg. No.	001	10101
н	* ≠	A	1. Decedent's Name (First, Middle, Last)						2.	. Date of De		Year	3. Time of Death
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30			Mary land ores	rerue Hesp	Has	- 7	nder 1 Year		er 24 Hrs. 8.	. Date of Bir		/A	hplace (State or Foreign
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr		rs. Mon		Hours	Min.	(Month, Da	y, Year)	Co	untry)
1	Director	-	215-24-1669 Usual Residence of Decedent		90				<u> </u>	FEB 8	1909	VI	RGINIA
puel	iow at		10a. State 10b. County	10c. (City, Town	or Location							10d. Inside City Limits
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ă ă	or 28; e not	Director	10e. Street and Number			10f	Zip Code				10g. Citize	n of What Co	ountry?
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ING ZIZIS-UUSO	iges I and 2 should be fined within 12 hours after death with the wearyan it for Health and Mental Hydrene. If for Health and Mental Hydrene. If for Exemple 27 is marked other type "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Exempler must be notified at	edt	15. Decedent's Educ	eation	16a.	Decedent's	Jsual Occup	ation			16b. Kind	of Business	Industry
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and	al Hy d other	Be (17. Father's Name (First, Middle, Last)					18. Mot	her's Name (I	First, Middle	, Maiden Si	urname)	
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<u> </u>	of the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	4 ☐ Homicide determined	building, etc. (Spe	ecify)	im, succi, ic	ictory, omco		20		wn, State)	740111007 01 7	and House Harrison,
_	spital ours ours ours ours ineral		29a. Certifier 1 Certifying Phy	sician: To the best of my	knowledge	e, death occu	rred at the t	ime, date	and place, ar	nd due to the	e cause(s) a	and manner a	s stated.
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	if		30. Name and address of person who co	ompleted cause of death (tem 23a)	(Type, Print)	7.6	61	Mar.	1 1	1	0	Was LA
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	Sta Regist	ate	31. Date filed (Month, Day, Year) APR 3	32. Redistrar's Si	gnature	A STATE OF	Me						=

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 SAMUEL HOWARD HARCUM, JR. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A If Under 24 9. Birthplace (State or Foreign If Under 8 Date of Birth 7. Age *(In yr*s **7**8 Social Security Number 09/28/1928 **Funeral** Hours 1**⊠**M 2□F 218-22-9018 MARYLAND **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State ral" or items 23a or 28a-f show Ext miner must be notified at 1 XYes 2 No BALTIMORE CITY N/A MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21229 4226 COLBORNE ROAD Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Wes 2 ☐ No US
If Yes, Give ARMY
Year or Dates 1 9 51 - 53 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 X No and 21215-0036 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Injury or other traumatic event, the Medical 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) US SOCIAL SECURITY College (1-4or 5+) Elementary/Secondary (0-12) ADMINISTRATION COMPUTER PROCESSOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental I FLOSSIE WATKINS 1 and 2 should be SAMUEL H. HARCUM, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4226 COLBORNE ROAD, BALTIMORE, MD 21229 ANTHONY H. HARCUM SON Health a Department of Heal Important: If item 2 any Injury or other Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages -Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/4/07 MD VETERANS CEM. OWINGS MILLS, MD GARRISON FOREST HOWELL FUNERAL HOME 21207 21. Signature uneral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death 23a. PA Immediat ause (Final disea condition resulting in death) LROSEPSIS **Physician** edical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Entirely Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as nse (IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 □ No 3 Probably 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No 2 No 1 ☐ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: or Attending After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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Registrar

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Division or Vital Records, P.O. Box 68760,	The last standard of the stand

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		GOOD 5. Social Security N		110111		ast birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h .	9. Birt	hplace (State or Foreign
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or 22	Dire	10e. Street and Nur	mber Irbridge	Poad			10f. Zip Code 21047			USA	of What Co	ountry ?
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	cal	29a. Certifier (Check only	2 ☐ Medical Ex	Physician: To the best aminer: On the basis of	of examina	owledge, de ation and/or	ath occurred at the t investigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time	cause(s) a , date and p	ind manner a place, and di	as stated. ue to the cause(s)
the the the mplet	Medical	29b. Signature and	d titlesof@artifier	and manner s	ated.		29c. Licen	se number		29d. Date	signed (Mor	nth, Day, Year)
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Regist			APR 3 0	2007	Fred J.	K A	nouls					

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a

27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injur Wor 1 🗌	</th <th>2 🗆 No</th> <th>28d. Describe</th> <th>how injury occurred</th>	2 🗆 No	28d. Describe	how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fa fy)	ctory, office				(Street and Number or Rural Route Number, own, State)
								e cause(s) and manner as stated. e, date and place, and due to the cause(s)
29b. Signature and t	itle of certifier	Λ.		29c. Licens				29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

he and address of person who completed cause of death (Ifem 23a) (Type, Print) Leunde. Usan

D33943 4/28/2007 2434 W Belvedere 21215

_o State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** 200) /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral 1□M 212F Months Days Hours 213-30-2713 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD treumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21216 110.5 or Items 23a Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 2 Married 1 Never Married Baltimore, Maryland 21215-0036 1□Yes 2XNo Specify: þ 3 ☐ Widowed ♣ Divorced Black 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DONOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then ' Elementary/Secondary (0-12) Obliege (1-4or 5+) rator Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 101a 9h mar John son way 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Windsor M:11, On D 2/244 3617 toole Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Baltimore InD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenset Funeral Services any Baltimore, and 21229 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physiclan/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No page 2 should 24a. Was an autopsy performed Were autopsy findings available prior to completion of cause of death? certificate 2 \(\text{No} \) 1 🗌 Yes 2 No 1 Yes To the Hospital or Attanding Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: P 1 🗌 Yes 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1. Natural s after decret Attended by the fire 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Funerel Directory filled in by 4 Homicide 29a. Certifier Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and Ittle of certifier

10

State Registrar 30. Name and address of

34. Date filed (Month, Day, Year)

APR 3 0 2007

2434 W. Belvedere Ave. Baltimore, MD21215

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Physician /Medical Examiner The law requires that the death certificate be executed

Box 68760.

O.

Division or Vital Records, P.

To the Hospital or Attending

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show

Director

Funeral

þ

Completed

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic event once.

Examine attending physician for use as the buria Physician/Medical as the ed by the a been signed t \$ Completed Be P this nours after death. Ineral Director: After the filled in by the funeral Certification: 24 hours a

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

within 24 ho To the Fun completely

Medical

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certific

6701 1 670 N 32 Registrar's Signaphre

29c. License number

D47221

April 23, 2007

29d. Date signed (Month, Day, Year)

Charles Street Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Gay 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ANDI L 200 T JUHNSON Physician 7.00-A.M EDITH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Baltimore Northwest Hospital

5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9/1/1927 Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2X F Yrs. 79 123-32-2967 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Baltimore MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 3612 Landbeck Road 21207 Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. African 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 □ Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7; th and Mental Hygiene. '7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esther M. Brown Richard Watkins, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun Angela M.Watkins/Daughter <u> 2107 Poplar Grove Baltimore, Maryland 21216</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/3/2007 Loudon Park |Balto., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit WylieFuneral Home of BaltoCo Signature (Fundry) Sarace 9200 Liberty Rd.Randallstown.MD f. Par. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lum diate Cause (Final sease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending physic for use as the b IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 menths? 1 ☐ Yes 2 Ø No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has b irector, page 2 sh autopsy performed? Yes 2 ☐ No 1∏ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 1 24 hours after death.
In Funeral Director: A sletely filled in by the full 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical To the Hosp within 24 hou To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. License number

29d. Date signed (Month, Day, Year)

April 26 9 2007

Northwest Hygnital Cents 29b. Signature and title of certifier 154288

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramamamu

31. Date filed (Month, Day, Year) APR 3 0 2007

danemas

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 0555 AM TOHNSON DAVID APRIL 22 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HARBOR HUSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 60 Nov 14, 1946 **Director** 217-44-1826 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1 ☐ Yes 2√∑ No Harford Bel Air Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or the Medical Examiner must be 21014 USA 103 Stoneleigh Road Funeral 14. Race - American Indian, items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married , o Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: white ð 3 ☐ Widowed 4 X Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) marked other than <u>disabled</u> none unk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumests. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Johnson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glenn A. Robinson/cousin 109 A Linthicum Drive Cambridge, MD 21613 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4□Donation 5XiOther (Specify) in state State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Servic Licensee Wade Director Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS LIVER **Physician** Week /Medical Due to (or as a consequence of) IV DECUBITUS VICER & Sequence of): HEPATITIS B/C Examiner 1 month Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed bunal-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical as the attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown THROMBOCYTOPENIA Completed 24b. Were autopsy findings available prior to completion of cause of death? COAGIULOPATH 24a. Was an autopsy perform 21 No 2 No 1 ☐ Yes MEPATIC ENCEPHALOPATHY Division or Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 210 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

24 hours a er deat Hospital the

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the within 7

29b. Signature

29c. License number

29d. Date signed (Month, Day, Year)

RES 001

APRIL 22 2007

30. Name and dress of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

S. HANOVER ST., BALTIMORE, MD 3001 31. Date filed (Month, Day, Year)

State Registrar

Medical

29a. Certifier

(Check only one)



07-0	316	5
Jun	Tae	Kim

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

in Tae Kim		I- For State Registrar	State	of Maryland		rtment o tificate o		ina Menta		Reg. No.	21	007	137	114
Physicia ledical Exami	ın/	1. Decedent's Name (F		t)			-		2. Date of D Month	Day	Year	3.	Time of Death 0616 hrs	
euicai Exami	ilei	Jun Tae 4a. Facility Name (if no		e street and number)		Т	4b. City, Town,	or Location of I	April 25, Death		c. County of	Death		
		9195 Furrow A	Avenue				Ellicott Ci	ty			Howard			
Funeral Director		5. Social Security Num 143 52 6988		7. Ag		st birthday) Yrs		ear If Under 2 ays Hours	Min. 07/19			9. Birthp Count Kore		eign
би		Usual Residence of De 10a. State 10	ecedent b. County		10c. City,	Town or Loca	tion					10	d. Inside City Lim	nits
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darylar 28a-f s 1 at on	Director	10e. Street and Number				_	10f. Zip Code			,	izen of Wha	,		
th the Maryland 23a or 28a-f sho notified at once.		9195 Furro	w Ave.				210				nited			
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status1 Never Married	2 X Married	12. Was Decedent Armed Forces? 1 Yes 2					? (Specify Yes or uerto Rican, etc.)	No-	White,	etc.	n Indian, Black,	
after c ral", o	۾	3 Widowed		If Yes, Give Year or Dates:		1	Yes 2 X				Specify: 7			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	eted	15. Decedent's Educ Elementary/Second		nly highest grade con College (1-4 or			nt's Usual Occu nost of working			16b.	Kind of Bus	iness/Ind	ustry	
5-0036 ited within 72 Hygiene. I other than the Medical	Comple	12	,(5,		,	Cook				1	Restau	ırant		
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2121 ould be fi Mental marked ic event,	To Be	unknown 19a. informant's Name	e/Relationship (7	Type, Print)		19b. Mailin	g Address (St		Soon June or or Rural Route N		City or Town	, State, Z	p Code)	-
MD do 2 shouth and n 27 is sumation		Ok Boon F	Kim/wife	·· ·		1	Furrow		Ellicott			210		
ore, land of Heal		20a. Method of Dispos		Removal from St		lace of Disporematory or of	sition (Name of ther place)	cemetery,	Date	20c.	Location - (City or To	wn, State	
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Donation 5	Other Specify				nthicum	Cem.	4/26/200	7 C	Larksv	7ille	, MD	
Bal permit Depar Impo		21. Signature of Fune	1	D. N.	M0144				Harry H. ia Pk. 1					
Physician		23a. Part I. Enter the of failure. List only	lisease, or comp		the death.	Do not enter	the mode of dyi	ng, such as care	diac or respiratory	arrest, sh	ock, or hear	rt rt	Approximate Inter Between Onset a	rval
/Medical Examiner		Immediate Cause (Fir	al disease a.	Atherosclerotic			ease						Death	ii id
		or condition resulting	b	Due to (or as a conse	equence of):								
	miner	Sequentially list condi- if any, leading to imme cause. Enter Underly	ediate	Due to (or as a conse	equence of):								
	Exami	(Disease or injury that events resulting in de	initiated c.	Due to (or as a conse	equence of):								
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit		LINDENDED	d.											
50, te be e: nysiciar s burial	Medical	UNPENDED IF FEMALE:		AMENDED 23c. If yes, outcor	me of predic	ancv				23	d. Date of o	lelivery		
687(ertifica ding pt e as the		23b. Was decedent pre past 12 months?	egnant in the	1 Live birth		. 2 🔲 F	etal death	3 Ectopic p	regnancy	-	Month	Day	Year	
Box death of attern d for us	Physician/	1 Yes 2 No	9 Unknow	4 Pregnant at 9 Unknown	time or dea	^{ath} 5 0	ther (Specify)							
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rds, P									24a. W	Yes 2	No 3		by 4 Unknown	
cords, law requir has been s	Completed								au	topsy rformed?	pr		pletion of cause	
Vital Rec yshcian: The his certificate		25. Was case referred	to medical				26 PI	ace of Death (C		s 2 🗸	No 1	Yes	2 No	
Vita hysician this cer	o Be	examiner? 1 ✓ Yes 2		Hospital: 1 Inpatie	ent 2	ER/Outpatien	personal control	Othor	Nursing Home 5	Resid	ence 6 🗸	Other: S	cene	
ing Phy After ti funeral	T:TC	27. Manner of Death 1 ✓ Natural		28a. Date of Inju (Month, Day,)	Iry 'ear)	28b. Time of	Injury 28c. i	njury at Work?	28d. Describ	oe how in	jury occurre	d		
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Divising pital or At ours after deral Direct filled in by	Certification:	3 Suicide 6	Could not determine	be	Jory Title		, , , , , , , , , , , , , , , , , , ,	o bonanig, oto.		n, State)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,
		29a. Certifier 1 Ce	ertifying Physic	ian: To the best of m	y knowledg	e, death occu	rred at the time	, date and place	e, and due to the ca	ause(s) a	nd manner	as stated	auge(e)	
To the How within 24 h To the Fur	Medical	one) 2 Me	///	r:On the basis of exa and manner stated.	mination ar	nd/or investiga		ense number	rred at the time, da		Date signe			
	-	255. Signature and uti		1.1	016	100		C.M.E.			ril 25, 20	,	,,, , , , , ,	
27		30. Name and address	of person who	compteted cause of c	leath (Item	23a)								
3		Tasha Greent		Assistant Medic			Penn Stree	et, Baltimore	e, MD 21201					
Si Regis		31. Date filed (Month,	3 0 200	2. Registra	r's Signatu	re	Z A							

			For State Registrar	State of	Maryland		artmen rtificat			and Me	, ,	jiene	07	1374	6
			Decedent's Name (First, Middle,	Last)			-			2	. Date of Dea	th		3. Time of Death	
	Physici		CHRISTINE A	. KULINSK	I						Month	Day	Yeer	10:08 P	М
	/Medic Examir		4a. Facility Name (If not institution,	give street and numb	ber)		4b. City,	Town, or	Location of	_	APRIL	2.5 4c. Coun	2007 ty of Death	<u> </u>	
	Exami		GREATER BALTIM	ORE MEDIC	CAL CENT	ΓER	TOV	SON				BALT	IMORE		
	Funeral			. Sex 7	. Age (In yrs. la		If Under	1 Year	If Under	24 Hrs. 8 Min.	. Date of Birth (Month, Day		9. Birthp	lace (State or Forei	ign
	Director		530-14-4878	1 □ M X (X(F	88	Yrs.	Months	Days	Hours	MID.	12/25/	1918	MISS	ISSIPPI	
	D .		Usual Residence of Decedent 10a. State 10b. County		100 City	Tour or Lo								The Color	
	anyla sho	<u>_</u>				Town or Lo							'	0d. Inside City Limit 1 ☐ Yes 2 🛣 N	
(D	ith the Marylar or 28a-f show	Director	MD BALTIN	ORE	PA	ARKVIL									
-	death with the Maryland ms 23s or 28s-f show r must be matified at		10e. Street and Number				10f. Zip				1	0g. Citizen of		try?	
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- 	iter d	5	1 Never Married 2 Married	Armed Ford	es?	13. 1	f Yes, spec	offy Cubar	, Mexican	n, Puerto Ri	can, etc.)		ack, White,		
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5-0036	72 hours after death w "naturel", or items 23e	ted	15. Decedent's	Education		16a. Deced	dent's Usua	al Occupa	tion			16b. Kind of	Business/Inc	dustry	
2 2 2	within 72 ane. than "nai	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4	4or 5+)	life. L	kind of wo DO NOT u	rk done di se retired)	uring mosi	t of working					
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and	al Hy	Be (17. Father's Name (First, Middle, La	ist)					18. Mothe	r's Name (/	First, Middle, i	Maiden Suma	ime)		
<u>×</u>	Menid h	2	JAMES G. ARMSTF	RONG					THE	ELMA F	REID				
\mathcal{I}	2 shc and ie m	9 3	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address	(Street a	nd Numbe	er or Rural F	Route Number	r, City or Town	n, State, Zip	Code)	
S	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 ie marked other then "natural", or items 23e or 28e-1 shot other traumatic event, the Medical Examirer must be notified at		JOSEPH KULINSKI	/SON	1001 01	1811			F RO		ALTIMOF	_	2123		
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			23a. Part1. Enter the disease, or co shock, or heart failure. List or	ly one cause on each	ch line.	Do not ente	er the mod	e or aying	, such as	cardiac or r	espiratory arr	est,		Approximate Interval Between Onset and Death	
	Physician /Medical	VC V	Immediate Cause (Final disease or condition resulting in death)	_a <i>SE</i>	3P51S	>									
	Examiner		,	Due to (or	as a conseque	ence of):	W /	xic c		-10					
		E.	Sequentially list conditions if any, leading to immediate	b. Due to (or	r as a conseque			4. 4. 1	-10	ILE					
S	uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		·										
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9															
ŏ	ath certit attending for use as	by Physician/Me	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnan		Ectopic pr	eanancy					ate of delive	ry	1
Э.	ne death the atte	sicis	in the past 12 months? 1 Yes 2 No		nt at time of dea		Other (sp					N	lonth	Day Year	
Ρ.Ο	that the de ed by the detached	Phy	9 ☐ U⊓known					77-7-		-					
Ś	res tha Igned be del	þ	Part II. Other significant condition:	1		ting in the ur	nderlying c	ause givei	n in Part I.			_		ne cause of death?	
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/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hoomitals d				1 -		of Death	Check only on	0)			
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u C	ding F th. After funera	<u>6</u>	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of (Month,	Day Year)	28b. Time of Injury		8c. Injury Work			d. Describe ho	ow injury occu	ırred		
isic	death death ctor: A y the fu	cat	2 Accident investigat 3 Suicide 6 Could no	be 200 Blace o	flairer Ather	(М		es 2 🗆 f		Landin (C	ter at a sel Africa		10-1-11-1	_
Division of Vital Records, P.O. Box	or A after Direction by	Certification:	4 ☐ Homicide determine	ed 286. Place o	f Injury - At hor g, etc. <i>(Specify)</i>	ne, tarm, stre	eet, factory	f, office		281	City or Town	reet and Nutr n, State)	nder or Hura	l Route Number,	
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	Hos 24 ho Fun etely	Medical	(Check only 2 Medical Ex	aminer: On the bas	is of examination	on and/or inv	estigation	, in my opi	inion, deal	th occurred	at the time, d	ause(s) and n ate and place	, and due to	the cause(s)	
	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely tilled in by the funeral director, page 2 should be detached for use as	Me	29b. Signature and title of certifier				290	. License	number		2	9d. Date sign	ed (Month,	Day, Year)	
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			30. Name and address of person wh			23a) (Type. i	Print)			,				7 MD 420	الدو
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	Sta	ite	31. Date filed (Month, Day, Year)	32. Re	istrar's Signati	1LB	0-			;					
	Registr	ar	ADD Q	n anna 🗆 🖾	9.0	12 1	Lagaria	9							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2300 **Physician** 25° 2007 Thelma Κ. Knril Long /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and nu Examiner Hospital of Baltimore Baltimore N/A City B. Date of Birth (Month, Day, Year) April 2, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 💢 F 90 214-01-6945 Mary land Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f shov iral", or items 23a or 28a-f show Examiner must be notified at Baltimore 1 DeYes 2 No Md. N/A Director the 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number 21212 USA 116 East Melrose Ave. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ White 3 Widowed 4 □ Divorced "natural" Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within ind Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) marked other than **Executive Secretary** Ship Builder 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annabelle Wienecke Christian F. Kamka ၉ and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) f Health 2934 Brookwood Rd. Ellicott City, Md. 21042 Mrs. Claire Hetrick/ Niece permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐ Removal from State Hilltop Service Co. 4-30-07 Towson, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Juneral Service Li Insee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardia Physician Acute /Medical Due to (or as a consequence of): Examiner Atherosclenotic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 Probably 4 Unknown Stendark 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 24a. Was an autopsy perforn certificate Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and due to the cause(s). Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 cause of death (Item 23a) (Type, Print)

State Registrar 30. Name and address of person who completed

31. Date filed (Month, Day, Year)

WIBERG

MO 32. Registrar's Signature

DHMH 17 Rev 1/2001

Sinai Hospital of Baltimore

	Phy:	sici	an
	/Me	edic	al
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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

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29a. Certifier (Check o one)			Examiner: On		examinati						e, and due to the urred at the time,					
	g and title							c. License							v, Year)	

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Registrar

State

31. Date filed (Month, Day, Year)

APR 3 0 2007

B. Bellevin

Garles

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			For 1 _ State	State of Ma	aryland		artment of F rtificate of		Mental Hy	/giene	Э	
			State Registrar 1. Decedent's Name (First, Middle, La	st)		Cei	lilicate of	Dealli	2. Date of De	Reg. No	Z. U U	3. Time of Death
To:	Physici /Medic		Marga	ret	Franc	ces	Narg		April			12:10P M
ì	Examin	er	4a. Facility Name (If not institution, giv Gilchrist	ŕ				r Location of Death	1	40	County of De	imore
	Funeral	-3.	5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. la:	st birthday)	If Under 1 Year					rthplace (State or Foreign Country)
	Director		215-05-6488	1□M 2 X F	94	Yrs.	Months Days	Hours Will.	Feb 2	8,1	913 N	laryland
	/land ow at		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	e Mar 3a-f sh tiffied	Director	Maryland Balti	more		Pik	esville	<u> </u>				1 □ Yes 2 💢 No
	with the		10e. Street and Number				10f. Zip Code	000		10g. Ci	tizen of What C	
	Jeath Trs 23	Funeral	3226 Marnat Road	12. Was Decedent	Ever in U.S.	. 13.	212 Was Decedent of H If Yes, specify Cubi		pecify Yes or No	0-	U.S.A 14. Race - Am	erican Indian,
ထွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	, Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 💢 If Yes, Give	No		lf Yes, specify Cuba 1 □ Yes 2 □ X No	an, Mexican, Puèri Specify:	io Rican, etc.)		Black, Wh	ite, etc.
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ž	should nd Me mark	은	Michael 19a. Informant's Name/Relationship		etta	19b. Mailir	ng Address (Street		lennie Jral Route Numb		Leone or Town. State.	Zip Code)
Baltimore, Maryland 21215-0036	and 2 salth ar		Roberta Lee	Niece			bury Lane		sbury,			
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	To with		29b. Signature and title of certifier	Alle	an.		02J	205		A 0	ate signed (Mor	7,2017
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	Sta Registr	_	31 Date filed (Month, Day, Year) APR 3 0 20	Hegistr	ars Signatu	ire Cons	well					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** NEIGHOFF 0652 AM 23 ASSANDRA MPRIL 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALAMONE MANYLAND UNIVORSITY OF N/A 8. Date of Birth (Month, Day, Year 6/18/1985 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** Days Hours 1□ M 2 🔏 F MARYLAND 213-11-6681 21 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 X No Funeral Director BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10e Street and Number USA 14. Race - American Indian, 4790 BYRON ROAD 21208 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11 Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE Specify. Completed by 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SCHOOL STUDENT 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ith and Mental h. Be 1 and 2 should be TONY NEIGHOFF MARY JENKINS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health a ant: If Item 27 is ury or other trai MD 21208 20c. Location - City or Town, State JEFFREY ASHKENASY/UNCLE 4790 BYRON ROAD BALTIMORE, MD Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition CEMETERY, CREMETORY OF UNITED PROCESSION OF STREET OF STREET OF STREET OF STREET OF STREET OF STREET OF STREET OF STREET OF STREET OF STREET OF STREET OF STREET OF STREET OF STREET OF STREET OF STREET OF STREET OF STREET N Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. TOWSON, MD Approximate Interval Between Onset and Death THROMBOEMBOLISM Immediate Cause (Final disease or condition resulting in death) DAYS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter of carrier Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transi Due to (or as a consequence of) physician a Physician/Medical as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes DUSTROPH Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s autopsy performed 1 Tyes 2 14No 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ۲ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: or Attending 1 Natural 5 Pending investigation within 24 hours after uea....

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Division or Vital Records,

31. Date filed (Month, Day, Year) APR 3 0 2007

mero

29b. Signature and title of certifier

UNIVERSITY



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SOUTH GREENE ST.

29c, License number

17385

29d. Date signed (Month, Day, Year)

BALTIMORE, MD

APRIL

DIESORIERD

2007

21201

07-03144	
Liza Pridgen	

za Pridgen	State of Maryland / Department of Certificate of State of Maryland / Department of Certificate of State of Maryland / Department of Certificate of State of Maryland / Department of Certificate of State of Maryland / Department of Certificate of State of Maryland / Department of Certificate of State of Maryland / Department of Certificate of State of Maryland / Department of Certificate of State of Maryland / Department of Certificate of State of Maryland / Department of Certificate of State of Maryland / Department of Certificate of State of Maryland / Department of Certificate of State of Maryland / Department of Certificate of State of Maryland / Department of Certificate of State of Maryland / Department of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of State of Certificate of	of Health and Mental Hygiene of Death Rei	g. No. 2007 1375
	Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
ledical Examiner	LIZA PRIDGEN Lisa Lorraine Pridgen	Month April 24, 20	4c. County of Death
1)	4a. Facility Name (if not institution, give street and number) 4109 Oakford Avenue	Baltimore	Ν/A
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		h(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	217 00 0222	Yrs. Months Days Hours Min. 3/02/	1966 Country) MD
	Usual Residence of Decedent	cation	10d. Inside City Limits
w any	Tob. County	MORE CITY	1 XYes 2 No
faryland 18a-f show 1 at once. ector	10e. Street and Number		0g. Citizen of What Country?
the Maryland or 28a-f shuiffed at once	637 WILLOW AVENUE	21212	USA
h with the mas 23a	11. Marital Status	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
r death or iter	1 A Never Married 2 Married 1 Yes 2 X No	Yes 2 X No specify:	sBI _s ACK
ural", miner	or Dates:	dent's Usual Occupation (Give kind of work done	16b. Kind of Business/Industry
72 hour	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use retired) URITY GUARD	SECURITY
5-0036 led within 72 hour lygiene. other than "natu the Medical Exan Completed	12 SEC	18.Mother's Name (First, Middle, N	
filed v filed v fillygi ed other fr the L	WILLIAM PRIDGEN	NORMA MYERS	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Interest 1 is marked other than "natural", or items 23s or 28a-fahe or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	illing Address (Street and Number or Rural Route Num 7 WILLOW AVE, BALTIMO	nber, City or Town, State, Zip Code)
MD d 2 sho Ith and In 27 is		sposition (Name of cemetery, Date	20c. Location - City or Town, State
re, f Hea If ite	20d. Method of Disposition	or other place) ON CEMETERY 5/3/07	LANSDOWNE, MD
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr	4 Denation 5 Other Specify:		TINERAL HOME 21207
Bal permi Depar Impo injur	21. Signature of Fulletian oct Model	4600 LIBERTY HEIGHTS	FUNERAL HOME 21207 AVE, BALTIMORE, MD
Physician	13. Pall the disease, or complications that can led the death. Do not en failure. Let only one cause on each line.	ter the mode of dying, such as cardiac or respiratory arr	rest, shock, or heart Approximate Interval Between Onset and Death
Medical	mp diate Cause (Final disease a. Seizure Disorder		- Journ
	Condition resulting in death) Due to (or as a consequence of):	ll.	
i.e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
ed nsit	(Disease or injury that initiated events resulting in death) Last		
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the death certificate by the attending physiched for use as the butter of the physiched for use as the butter of the physical and the physical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregnancy	Month Day Year
ox 6 ath cer attendi	past 12 montus? 4 Pregnant at time of death 5	Other (Specify)	1
Division of Vital Records, P.O. Box 6876C Is no Attending Physician: The law requires that the death certificate and prier death. In Director: After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the beautiful to the funeral director, page 2 should be detached for use as the beautiful to the funeral director, page 2 should be detached for use as the beautiful to the funeral director, page 2 should be detached for use as the beautiful to the funeral director, page 2 should be detached for use as the beautiful to the funeral director, page 2 should be detached for use as the beautiful to the funeral director, page 2 should be detached for use as the beautiful to the funeral director, page 2 should be detached for use as the beautiful to the funeral director, page 2 should be detached for use as the beautiful to the funeral director, page 3 should be detached for use as the beautiful to the funeral director, page 3 should be detached for use as the beautiful to the funeral director, page 4 should be detached for use as the beautiful to the funeral director, page 5 should be detached for use as the beautiful to the funeral director, page 5 should be detached for use as the beautiful to the funeral director, page 6 should be detached for use as the beautiful to the funeral director, page 7 should be detached for use as the beautiful to the funeral director and the funeral dir	Part II. Other significant conditions contributing to death but not resulting in	the underlying course give	tobacco use contribute to the cause of death?
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Records, I The law requires ficate has been sign, page 2 should be			ppsy prior to completion of cause of death?
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ian: J	25. Was case referred to medical	26.Place of Death (Check only one) atient 3 DOA Other Nursing Home 5	Residence 6 V Other: Scene
F Vid	1 V Yes 2 No Imparent 2 28b. Tim	attent o box	e how injury occurred
on on on on on on on on on on on on on o	1 X Natural 5 Pending (Month, Day,Year)	1 Yes 2 No	
VISIC or Atte Ter des Directo	1 X Natural 5 Pending Investigation 2 Accident Could not be determined (Specify)	s, street, factory, office building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City , State)
Divis Divis Divis Diplication of the properties of the properti	4 Homicide determined (Specify)	determined and place and due to the ca	use(s) and manner as stated.
		estigation, in my opinion, death occurred at the time, date	te and place, and due to the cause(s)
To the within To the comple	Certifying Physician: 10 the best of my knowledge, dearly one) 2 Medical Examiner: On the basis of examination and/or inverse and manner stated. 29b. Signature and title of certifier.	29c. License number	29d. Date signed (Month, Day, Year)
	MANM	O.C.M.E.	April 25, 2007
	30. Name and address of person who completed cause of death (Item 23a)	Penn Street, Baltimore, MD 21201	
	Oddan Florida At at Day Year's Registrar's Signature	reini Sueet, Daitimore, MD 21201	
Sta			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ž7, Pavuk Apri1 Mary 2007 5:30 a^M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Manor Care Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02/13/1913 Birthplace (State or Foreign Country)
 PA 5. Social Security Number 196–34–4636 7. Age (In yrs. last birthday) 6. Sex **Funeral** 94 Months 1 ☐ M 2 🛣 F Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. Counfy r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Montgomery Bethesda 1 TYes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with Democracy Boulevard 20817 USA 6530 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify. Specify: þ **3** Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd 2 should be filed within 73 ath and Mental Hygiene.
27 Is marked other than "n r traumatic event, the Medi Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Hegedus Pages 1 and 2 should be Michael W. Prokop 19a. Informant's Name/Relationship (Type. Print)
Patricia Tino / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10509 Edgefield Drive, Adelphi, MD 20783 permit. Pages 1 and 2 s
Department of Health ar
Important; If Item 27 Is
any injury or other trau altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Locust Grove Cemetery April 30,2007 Ellwood City, 4 ☐ Donation 5 ☐ Other (Specify) Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21. Signature of Funeral Service Licensee 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimer's Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Hypertension **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Osteoporosis Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician at the burial Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Constipation 1□ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 No this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: 27. Manner of Death After (Month, Day Year) Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Registrar DHMH 17 Rev 1/2001

the within 2 To the

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29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Kirti Vohra, M.D.

APR 3 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa ure

Medical

State

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

7710 Bradley Boulevard, Bethesda, MD 20817

29c. License number

D-20274

29d. Date signed (Month, Day, Year)

April 27, 2007

Catonsville

10f. Zip Code

1 ☐ Yes 2 💢 No

16a Decedent's Usual Occupation

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -^{Day}2007 April 17, 7:00 AM M Jacqueline Z. Palmer 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlestown Health Center Catonsville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
111inois 5. Social Security Number 7. Age (In yrs. last birthday, 85 Aug 6, 1921 376-20-7279 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits

21228

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

1 ☐ Yes 2√ No

10g. Citizen of What Country?

USA

16h Kind of Business/Industry

14. Race - American Indian,

Black, White, etc.

Specify: white

Funeral Director

Physician

/Medical

Examiner

For State Registrar

10a. State

MD

10e. Street and Number

1 ☐ Never Married 2 X Married

3 Widowed 4 Divorced

11. Marital Status

Baltimore

709 Maiden Choice Lane S 437

15 Decedent's Education

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates:

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examigner must he accessed. Director Funeral by 8

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-transit been signed by the should be detached certificate has b irector, page 2 sl within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

5	(Specify only highest grade	completed)	(Give kind of N	vork done	during most of wor	rking		, madon y
	Elementary/Secondary (0-12)	College (1-4or 5+) 5+			ounselor		education	on
	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, Maid	en Surname)	
	Arthur Zeuch				Vera	Grothe		
	19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailing Addre	ss (Stree	and Number or Ru	ural Route Number, Cit	y or Town, State,	Zip Code)
	Max Palmer/spouse		709 Maio	len C	hoice Lar	ne S 437 Ca	tonevil1	le, MD 2122
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☒ Donation 5 ☐ Other (Specify)	1 ^	lace of Disposition (Nemetery, crematory o	lame of	i i	Date 20c.	Location - City of	Town, State
	21. Signature Funeral Science License S. W.	ade, Direct	State	Anat	ess of Facility Comy Board MD 2120	d 655 W. Ba	ıltimore	Street
	23a. Part1. Enter the disease, or complic shock, of heart failure. List only one immediate Cal. (Final disease or condition		n. Do not enter the m	ode of dy	ng, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
	resulting in death)	Due to (or as a consequ	uence of):					
	Sequentially list conditions, b.	Des to form to the						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could be a conditionally lead to the country of the coun	Due to (or as a consequ	uence of):					
	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
		Due to (or as a consequ	derice oi).					
	ď.							
1	IF FEMALE:							
	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of degerations	I death 3 □Ectopic		Э		23d. Date of de Month	elivery Day Year
	Part II. Other significant conditions cont	tributing to death but not resu	ulting in the underlying	a cause qi	ven in Part I.	23e. Did tobacc	o use contribute	to the cause of death?
,		3		, 3		A		robably 4 □Unknow
, , , , , , , , , , , , , , , , , , , ,						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of s 2 \square No
	25. Was case referred to medical examiner?					ath (Check only one)		
	1 Yes 2 No Ho	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Ot	her: 4	lome 5 Residence	6 ☐Other (Sp.	ecify)
	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Inju	ıryat ırk?]Yes 2 ☐ No	28d. Describe how in	ijury occurred	
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	ome, farm, street, fact y)	ory, office		28f. Location (Street City or Town, St	a <i>nd Number</i> or F ate)	Rural Route Number,
		ician: To the best of my kno- er: On the basis of examina and manner stated.						
	29b. Signature and title of certifier		-	29c. Licen	se number	29d.	Date signed (Mor	th, Day, Year)
)	NP		D	1744)	A	11.19	7,7017
	30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, Print)	hen	Lare	(steam	my)
ĺ	31. Date filed (Month, Day, Year) APR 3 0 200	32 Registrar's Signa	ture Angell	,				
	APR 3 0 200	II fallen A	1. Williams					

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#8 perFH G867 5707 WS
State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 25, 2007 8:24 PM **Physician** April Helen Turner Quick /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 1205 Merediths Ford Road Towson 8. Date of Birth 1921 (Month, Day, Year) April 23, 07 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2**X**F Maryland 86 214-14-9849 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show notified at 1 ☐ Yes 2X No Director MD Towson Baltimore 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number o a USA 21286 1205 Merediths Ford Road "natural", or items 23a must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black. White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Examiner 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛛 No Specify: Specify: Saltimore, Maryland 21215-0036 White ò 3€ Widowed 4 □ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) Evergreen House Docent Is marked other 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in the sound be in the sound Mental int: If item 27 is marked o Louise Bush John Edward Turner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 Constantine Drive, Phoenix, MD. 21131 Walter S. Quick, III (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of P
Important: If ite
any injury or ot 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkville, MD. Moreland Mem. Park 04/30/2007 4 ☐ Donation 5 ☐ Other (Specify) Ruck Towson Funeral Home, Inc. 21. Signature Funeral Service Licenses 22. Name and Address of Facility 1050 York Road, Towson Maryland 21204 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition MONTHS ONGESTIVE Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending | IE EEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed: has 1∐ Yes 2∐ No certificate the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 this 28d. Describe how injury occurred After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident I Director: / d in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours at To the Funeral Completely filled i 😂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) ure and title of certifie 29b. Signat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 OSLER DAWE OSENBLUM NATHAN M 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State

Registrar

APR 3 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #9, prFH, g866, 4/30/07 TT

Certificate of Death

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month MARY SMITH 24 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Cromwell Rehab Center 8. Date of Birth (Month, Day, Year)

Feb 10 1919

8. Birthplace (State or Foreign County), A11A abarra **Funeral** 1□M 2€ F 88 Yrs. 216-14-8262 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at announce. 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 ☐ Yes 2 No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4509 Kenilworth Ave 21212 USA Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Griot/Storyteller Self Employed 12th 8yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rogers Ward Bertha Eartha 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan S. Stevenson(Cousin) 9028 Scotts Haven Dr. Baltimore, Md. 21234 20b. Place of Disposition (Name of cembter), crematery or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Memorial Park 4-30-07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21. Signature of Funeral Service Licensee Win Name Reddeer of &acilisons Mortuary, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail are. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** week /Medical Due to (or as a consequence of): **Examiner** RENAL DISTASE END STAGE Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ZVD To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bundal-transit completely filled in by the funerated director, page 2 should be detached for use as the bundal-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, HBP Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 2 **10**0 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Matural 5 Pending Injury 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4125/2007 Je42 to mes 8710 EMGE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CROMWELL CENTER, BALTMO MD TOWNYO 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

APR 3 0 2007

			1 - For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of F rtificate of		and Mental H	ygiene Reg. No.	0 0 /	10/00
ľ	Physic	ian	Decedent's Name (First, Middle, I	ast)	51	narpe		2. Date of E	eath Day	Year	3. Time of Death
	/Medi	cal	Baby box	/				Apri	17	,2007	0800 AM
	Examir	ner	4a. Facility Name (Mnot institution, Johns Hopkins		redical Cont	4b. City, Town, o		timo:	4c.	County of Death	
	Funeral Director		none	Sex 7. Ac 1 X M 2 □ F	ge (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours 26		ay, Year)	Cou	place (State or Foreign ntry) 1and
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					Od. Inside City Limits
	Mary B-f sh	to	MD Baltimo:	re	Baltimor	e				100	1 ☐ Yes 2√☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
	e 23e	erai	2416 Ridgely Sti		F 110 110		1237			USA	
980	72 hours after death with the Maryland natural', or itama 23a or 28a-f show Jistal Extariurat be notified at	by Funeral I	11. Marital Status 1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Yes 2 X If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🎇 No	Ispanic Orig an, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)		4. Race - Americ Black, White, Specify: bla	etc.
21215-0036	"natural",	Completed	15. Decedent's (Specify only highest of	Education rade completed)	16a. Dece	dent's Usual Occup	ation	of working	16b. Kir	nd of Business/In	dustry
121	d within giene. or than "	mple	Elementary/Secondary (0-12)	College (1-4or	5+) /ife.	DO NOT use retired	d)	or working			
0	Hygi Hygi ther	e Co	none 17. Father's Name (First, Middle, La.	none	none	unk	18. Mother	's Name (First, Middl	noi n Maidea		
lan,	Q 2 2 2	To B						ita Sharpe		, , , , , , , , , , , , , , , , , , ,	
Maryland	d 2 should the and Ment the and Ment ?7 is marked traumatic a	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number	r or Rural Route Num	ber, City or	Town, State, Zip	Code)
	s 1 and if Health item 27 other tr		Hopkins Bayview 20a. Method of Disposition	Med Ctr	4940 20b. Place of Dispo	Eastern	Avenue	e Baltimor			
Baltimore	0 0		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	ω) in state	cemetery, crei	natory`or other plac		Date		cation - City or To	
Bai	permit. Pag Department Important: I any njury o		21. Signature of Euner Service Lic ROD Ld S.	10000	Da	iltimore,	MD Z	oard 655 W 21201		timore S	treet
	Physician /Medical Examiner	J.	23a. Part Enter the disease, or co shock, or heart failure. List on Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Res	a the death. Do not ent ne.	er the mode of dying fails	ore furit	eardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):	1					
P.O. Box (To the Hospital or Attending Physician: The law requires that the death certif within 24 hours elter death. Within 24 hours elter death. To the Funestal Director: After this certificete has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy			23	3d. Date of delive Month	ery Day Year
۵.	res that signed b be deta	by Pt	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco us	e contribute to the	ne cause of death?
ğ	w require been sig should b	ted t	Hypotensia	ч				1	Yes 2	No 3 □ Prob	ably 4 Unknown
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Vita	rician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Oth		of Death (Check only	one)		
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ion	nding ath. r: Afte	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year) Injury	Worl	k? Yes 2∐N				
Divis	tal or Atte s efter der al Directo ad in by th	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home, farm, stro c. <i>(Specify)</i>	eet, factory, office		28f. Location City or To	(Street and wn, State)	Number or Rura	l Route Number,
	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Medical (29a. Certifying F (Check only one) 1 Certifying F 2 Medical Example 1	hysician: To the best miner: On the basis o and manner sta	of my knowledge, death f examination and/or inv ated.	occurred at the time restigation, in my op	ne, date and pinion, death	place, and due to the occurred at the time	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)
	To t To t Com	Σ	29b. Signature and title of certifier	P 214	~ n n.	29c. License				signed (Month,	
7			Muton	Lee No	roda, Ma	DOC)32568		Apr	17,0	2007
	_		30. Name and address of person who Shaton Lee W	completed cause of d	eath (Item 23a) (Type, I	Print)	(L)014	Fe Storet	Pril	timore	2007 Maryland
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	100,00		/	1,000		7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 3 per doc. 18 per fh 9866 4-30-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death APRIL **Physician** 23 2007 11:10 PM **STALNAKER** LESLIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE Under 1 Year | If Under 24 Hrs. 88 RIVER OAKS CIRCLE BALTIMORE 8. Date of Birth (Month, Day, Year 12/22/1948 9. Birthplace Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 🛣 F 58 Director 216-56-5965 Usual Residence of Decedent 10d. Inside City Limits 1∩a State 10b County 10c. City, Town or Location ms 23a or 28a-f show must be notified at 1 ☐ Yes 2**X**☐ No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b 21208 USA 88 RIVER OAKS CIRCLE Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

STENOGRAPHER should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LAW 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SAMUEL SPAYD 2 ALICE KAUFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is any Injury or other trau. once. STEVEN LEGUM / FIANCEE 88 RIVER OAKS CIRCLE, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE HEBREW 04/27/2007 REISTERSTOWN, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Met 6 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Que to (or as a consequence of): physician a the burial: Division or Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s autonsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Aatural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 3 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** APRIL HOMAS 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner KESVIL NURSING HOME DALTIMORE 9. Birthplace (State or Foreign Country) GEORGIA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours Min 1□M 2⊠F C 415-40-015 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director IKESVILLE MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number IDBROOK 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify Specify. \$ BLACK 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSING 8 THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HARLES WALTERS (NEPHEW. LTIHORE MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriat Cremation WOODLAWN 4 □Donation 5 Other (Specify) Funeral Service Licensee 21. Signature of JK. FUNERAL HOME 40 N. MA KNER and 1. Ent., the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory all est, lock, or sent failure. List only one cause on each line. Approximate Interval Between Opset and Death Inry diate Cause (Final to ase or condition resulting in death) doep Due to (or as a consequence of): weden NEUMONIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine DEMENTIA ENDSTAGE Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No 9☐Unknow Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only on Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 (Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed physician and s the burial-trans Vital Records, P.O. Box 68760. certificate has Hospital or Attending Physician: 24 hours after death e Funeral Director:

Funeral

Director

r 28a-f show notified at

ns 23a or 2 must be n

Examiner

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"natural",

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Department of Health and Important: If item 27 is m any injury or other traum

Physician /Medical

Examiner

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Maryland 21215-0036

Baltimore,

permit.

25

à Completed Be ပ္ Certification: Medical

within 2 State

(Check only one) 29b. Signature and title of certifier

4 Homicide

29a. Certifier

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c License number 29d. Date signed (Month, Day, Year)

555W. Towsontown, Blud

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) APR 3 0 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Dorothy Ann Teass 2007 April 08:10 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** Days Hours Min. 1 □ M 2 X X 057-09-9694 89 Yrs 09-15-1917 Director New York Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits sa or 28a-f show t be notified at show MD. Baltimore Towson 1 ☐ Yes 2 💢 💢 o Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 513 Locksley Road 21204 U.S.A. items 23a ner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married or. Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White þ Specify: 3XXWidowed 4 □ Divorced 'natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0wn Home Housewi fe 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Sr. James Francis Duffy, Charlotte Veronica ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. (Daughter) Gayle C. Mahoney 1658 Aberdeen Road, Towson, Maryland, 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Mount Maria Cemetery | 05-02-2007 | Towson, Maryland, 21204 4 □ Donation 5 □ Other (Specify) permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1050 York Road (R.G.Ruth) Ruck Towson Funeral Home, Inc. Towson, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last onse wence of Examine Due to lor as a the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical ast IF FEMALE: If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Division or Vital Records, P.O. 1 ☐ Yes 2 ☐ No. been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy certificate 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 TYes 2 TNo ieral Director: / 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I completely filled Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

ē

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death

Tull

APR 3 0 2007

(Nem 23a) (Type, Print)

2. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fb 2866 4-30-07 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** d-200 April 2 2001 TSIFERShaye /Medical Bashiva 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country RAINE 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 03/31/1922 **Funeral** 1□M 2**Z**F 218-33-6954 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show 1 □Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Merlal Hygiene. Introprant: If Item 27 is marked other than "natural" or Items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified any injury or other traumatic event, the Medical Examiner must be notified. Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 130 SLADE AVENUE. APT. #304 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) **BOOKKEEPER** CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ FREIMAN MUNYA GERSH ပ 19b. Mailing Address (Street and Number or Bural Boute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1689 GEMINI DRIVE, ELDERSBERG, MD GENNADY TSIFANSKY / SON 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 04/27/2007 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. Use only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bours Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter of indentiting Cause (Disease or injury that initiated events resulting in death) Last MAGKEE e neemalone to Due to (or as a consequence of): Examine burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Itemmaras Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural n 24 hours after death.

ne Funeral Director: Af
oletely filled in by the fur 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D29085 lece Mr-1 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 3 0 2007

5401

3 Registrar's Signature

			1 - For State Registrar	ate of Maryland		artment of H		nd Mental Hy	giene	2007	13761
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of Death
	/Media	al	Virginia J. Weber			# 01 T		April :	27.	2007	9:50 A.M
	Examir	er	4a. Facility Name (If not institution, give street Ruxton Health of Den			4b. City, Town, or		Death	4c.	County of Death	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	Dent If Under 1 Year	If Under 2		th Vans	Carolin 9. Birth	LE oplace (State or Foreign untry)
	Director		216-18-5166	%2F 84	Yrs.	Months Days	Hours	Min. (Month, Da Sept. 29			
	land ow		Usual Residence of Decedent 10a. State 10b, County	10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mary a-f sh	tor	Maryland Anne Arund	el Pasa	dena						1 ☐ Yes 2☐ No
	ith the or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cou	untry?
	s 23a	ral	1626 South Shore Pa			2112				ted Sta	
	fter de	by Funeral	Ar	as Decedent Ever in U.S med Forces? TYes 3.FTNo	. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origi n, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	-	 Race - Amer Black, White 	
98	ours a	by	- Court If	☐Yes 2,770No Yes, Give par or Dates:	1	I□Yes 2∏ No	Specify:			Specify: Whi	te
5-0	filed within 72 hours after death with the Maryland Hygiene. ythar than "natural", or Itams 23a or 28a-f show ant, Ita Medicul Evar, it et frast be ricitified at	Completed	15. Decedent's Education (Specify only highest grade com	pleted)	(Give	lent's Usual Occupa	furing most a	of working	16b. Ki	nd of Business/li	ndustry
12	within ene. than	dmo		ollege (1-4or 5+)		oo not use retired, nemaker)		Οw	n Home	
Maryland 21215-0036	illed Hygi othar ant, I	Be Co	12 17. Father's Name (First, Middle, Last)				18. Mother	s Name (First, Middle			
/lan	utd be Menta Irkad Itic av	ToB	Andrew Jackson, Sr	•				ımsaded Ha			
/an	2 should be filed v n and Mental Hygie is markad othar t raumatic avant, III		19a. Informant's Name/Relationship (Type, Pr	int)				or Rural Route Numb			p Code)
e, l	1 and Health am 27 ther tr		Geroge T. Weber / Son 20a. Method of Disposition	20h Pla		Greensbo		oad Green			21639
nor	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, it a Medical Examinatings to retified at 90cc.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	ar ir our otate		sition (Name of natory or other place	,	lay 1,		cation - City or T	
altimore,	permit. F Departme Importar any injur		21. Signatur If Funeral Service Licensee	Gren	22	Mem. Pk.	s of Facility	2007		n Burni	
m —	Per In De		> Jun Lebauge		Ki 42	rkley-Ruc Crain	ldick lwy. S	Funeral Ho E.E. Glen B	me P urni	ė, MD 2	1061
П			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. se on each line.	Do not ente	er the mode of dying	g, such as ca	ardiac or respiratory a	rest,		Approximate Interval Between
	Physician /Medical	H	Immediate Cause (Final disease or condition resulting in death)	SERSIS	>					1	Onset and Death
E	Examiner			Due to (or as a conseque	ince of):	Δ					DAIS
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque							
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events								
8760,	death certificate be executed e attending physician and id for use as the burial-transit	al E	, southly and	Due to (or as a conseque	nce or):						
687	g physical as the l	edical	d								
ŏ	feath certific attending p	an/M	250. Was decadent pragnant	res, outcome of pregnance		Ectopic pregnancy			2	3d. Date of deliv	өгу
Ö.	the dea y the att iched fo	Physician/Me	1 Yes 2 VNo	Pregnant at time of dea		Other (specify)				Month	Day Year
<u>.</u>	res that the de signed by the a be detached t	/ Ph	Part II. Other significant conditions contributi	ng to death but not result	ing in the un	deriving cause give	n in Part I.	23e. Did to	obacco us	se contribute to t	he cause of death?
rds,	- w D	ed by	END STAGE	DEUNEN	TIA			101	es 2 [No 3 Prol	bably 4 Unknown
ecord	aw requasi been 2 should	plete						24a. Was		24b. Were auto	opsy findings available
x	The ate h page	Completed						— autop perfo 1 ☐ Yes	med? 2 No	prior to co death? 1 ☐ Yes	mpletion of cause of
Vital	Physician: The this certificate	Be	25. Was case referred to medical examiner?	1.				f Death Check on o	1-		
ō	Phys	5	105 2010	Date of Injury 2	NOutpatient 8b. Time of		Nurs	ing Home 5 Resid			(y)
<u>0</u>	Attanding F death. ctor: After y the funer	atlon:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury Work M 1 \(\text{Y}	? ′es 2⊡No		,,		
Division	after death	Certificati	3 Suicide 6 Could not be determined 28e	. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tox		Number or Run	al Route Number,
	pital o		29a. Certifier 1 **Certifying Physician:	To the best of multiplied	-4 4-14						
	To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	edical	(Check only 2 Medical Examiner: O	n the basis of examination of manner stated.	eage, death n and/or inve	occurred at the time estigation, in my opi	e, date and i inion, death	occurred at the time,	ause(s) a date and	and manner as s place, and due t	tated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	100		29c. License	number		29d. Date	signed (Month,	Day, Year)
)	2		July Tran	Horenou	M M	DOD DOD	530	094	ADO	127 CS11	2007
	5	-	30. Name and address of person who complete	d cause of death (Item 2	За) (Туре, Р	(nnt) 771	2	10 11 15	11	Arc F.	DAMON M
	Sta	te	31. Date filed (Month, Day, Year)	Registrar's Signatur	at no	יועכע	0100	willow.	IYU	12 NS 16	WINGS IN
	Registr	-	APR 3 0 2007	som &	Spen						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - Registrar Amend Items 23a, 25 per me, g866, Wald 27/97 death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** WILCOX 11:10 A M FEBRUARY 08 KITA 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 7 HARROR HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country RGINIA 1 □ M 2 😾 F 217-50-0040 60 Director 4-13-1946 Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene.

dother than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County iral", or Items 23a or 28a-f show Examiner must be notified at BALTIMORE ROSEDALE 1 ☐ Yes 2 ☐ No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 U.S.A. 6303 FIELDVALE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed by Specify: WHITE 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natuu any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RAYMOND G. CHURCH GLADYS (UNK) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6303 FIELDVALE ROAD ROSEDALE, MD 21237 WILLIAM R. WILCOX/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) SACRED HEART JESUS 2-12-07 BALTIMORE, Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE. 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Atherosclerotic Cardiovaccular Disease. Approximate Interval Between Onset and Death CERTIFICATION APPROVED BY MEDICAL EXAMINER

CERTIFICATION APPROVED BY MEDICAL EXAMINER Atherosclerotic Cardiovascular Disease Physician MACH PG SEVERE Sersis with Complications disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): 68760, attending physician for use as the buria the death certificate be Physician/Medical Box (IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Récords, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of has death? 1 ☐ Yes certificate 1∐ Yes 2 No 2 \ No Vital Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2√1 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

3

31. Date filed (Month, Day, Year)

APR 2 7 2007

Namusa - MEDICAL BOCTOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



RESOOO

FEBRUARY 08 2007

			1 - State of Maryland / Dep	partment of Health and Nertificate of Death	, ,	ene g. No. 2007	1 10760
*	Physici		1. Decedent's Name (First, Middle, Last) Catherine Elizabeth White		2. Date of Death Month April 26	Day Year	3. Time of Death 10:10 A M
	/Medio Examin		4a. Facility Name (If not institution, give street and number) Gilchrist Center	4b. City, Town, or Location of Death	Whiti 50	4c. County of Death	re
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday 212-03-3426 Sex 1 M 2X F 93 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birti 1913 Mar	nplace (State or Foreign untry) ryland
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Director	10a. State 10b. County 10c. City, Town or L Maryland Baltimore Baltim 10e. Street and Number 10e. Street and Number 10e. Street and Number		10	g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 No
	s 23a or nust be		6513 Sharon Road	21 2 39		USA	
15-0036	ours after de ral", or item Examiner r	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ☒ ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🗖 No Specify:	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
0-6121	be filed within 72 hours after death with the Marylar ital Hygiene. 4d other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Memaker	sing	6b. Kind of Business/I	·
land 2	be filed Ital Hygi d other event, t	To Be Co	17. Father's Name (First, Middle, Last) Frederick Charles Schlingman	18. Mother's Nam	e (First, Middle, Mi cine Eliza		
, mary	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Clark White (son) 6513	ing Address (Street and Number or Rui Sharon Road, Balt	imore, M	D 21239	
saltimore	Page nent o ant: If ury or		4 Donation 5 Other (Specify)	Cemetery 04/3	80/2007	Oc. Location - City or Technology Parkville	, MD.
g	permit. Depart Importa any inji		Myh D.C	1050 York Road, To	wson, Ma	ryland 21	Home, Inc. 204
	Physician /Medical Examiner		23a. Part1. Either the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	ther the mode or dying, such as cardiac	Cless	st,	Approximate Interval Between Onset and Death
,007		al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):	the second			Jean
O. BOX 68/	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delin	very Day Year
cords, P.	quires that on signed by uld be deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	
al reco	~ Q 70	Completed by			24a. Was an autopsy performe	prior to c	topsy findings available ompletion of cause of
vision or vital	o the Hospital or Attending Physician: The law within 24 hours after death. We the Funeral Director; after this certificate has londered the funeral director; page 2 sompletely filled in by the funeral director; page 2 sompletely filled in by the funeral director; page 2 sompletely filled in the funeral director.	ation: To Be	25. Was case referred to nedical examiner? Yes 2 No	nt 3 DOA Other: 4 Nursing Ho	h (Check only one) me 5 Residen 28d. Describe how		in for its
DIVIS	ital or Atters after destal Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, so building, etc. (Specify)		City or Town,	1	
	the Hospi nin 24 hour the Funer npletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal check only one) 1 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, dat	e and place, and due	to the cause(s)
)		Σ	29b. Signature and title of certifier	29c. License number DJ-5 J W Print) N. Char Ce, S7		Date signed (Month	
/	Sta	te.	30. Name and address of person who completed cause of death (Item 23a) (Type	N. Charles Si	! Pou	loto. md	21204
	Sta Registr		APR 3 0 2007 Produce 18 Apr	all I			

Registrar

State

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Sinon Hospital of Baltima

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Year)

31. Date filed (Month, Day,

			For State Registrar	State of Ma	ıryland / l		artment of F rtificate of a			giene Reg. No.	Z 11 11 1	13765)
	-	1	Decedent's Name (First, Middle, L.)						2. Date of De			3. Time of Death	-
	Physicia /Medic	-	Elizabeth	Es	ther		Abe		April			1:23 A M	
)	Examin		4a. Facility Name (If not institution, g.	ve street and number)				Location of Death		4c.	County of Death		
	i na milatina "att " Marianna.		Memorial Hospita					erland			Allega		_
	Funeral		5. Social Security Number 6. 220-30-8294	Sex 7. Age 1	e (In yrs. last bi 1	rthday) Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)		nplace (State or Foreign untry)	
in the	Director		Usual Residence of Decedent		1		<u> </u>		05/26/	1935	Mar	yland	-
	/land		10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits	_
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	or 28k	Director	10e. Street and Number				10f. Zip Code			9	zen of What Co	untry?	
	23a oust b	la	498 Beans C	ove Road			1:	5534-8023			ISA		
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Healih and Mertal Hygiene. Important: If them 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give				lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.))-	14. Race - Amer Black, White		
	ral', o	by	3 Widowed 4 Divorced	Year or Dates:			1 □ Yes 21X No	Specify:			Specify:	White	
2	72 ho natur lical	Completed	15. Decedent's (Specify only highest of	Education erade completed)	16a	. Deced	dent's Usual Occup	ation during most of work d)	king	16b. Ki	nd of Business/I	ndustry	
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7	lled w Hygie her ti	S	12 17. Father's Name (<i>First, Middle, Las</i>	et)		S	eamstres	3 18. Mother's Nam	e (First Middle		ctory		_
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5	should nd Me mark matic	ဌ	19a. Informant's Name/Relationship					and Number or Ru					-
<u>8</u>	nd 2 sulth ar 27 ls r trau		Ronald F. Abe /				•	ve Road,					
ກຸ	s 1 al f Hea item othe		20a. Method of Disposition		20b. Place o	f Dispo	sition (Name of matory or other plac	ce)	Date	20c. Lo	ocation - City or	Town, State	-
2	Page rent o nt: If		1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		1			ory 04/19	9/2007	Cuml	berland.	MD	
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0	89 = 89	5 1	Tihert	C. Cul	aus	1	404 Decat	ur Street	t, Cumb	erla	nd, MD	21502	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each lin	the death. Do e.	not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	arre <i>s</i> t,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Dehyd	ration						-	Few Days	
	/Medical Examiner		resulting in death)		a consequence								
	A	<u>-</u>	Sequentially list conditions,		tatic		ephalopa	thy			_	Few Days	_
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0/00,	icate be executed physician and s the burial-transit	edical		d									
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Š	ath ce ttendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 🗌 Fetal deat		Ectopic pregnanc	/		1	23d. Date of deli Month	ivery Day Year	
5	the a	Physician/M	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4∐Pregnant at 9∐Unknown	time of death	5 L	Other (specify)						
Ţ.	that the	Ph)	Part II. Other significant conditions	contributing to death bu	ut not resulting	n the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?	-
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>	ysich is cer direct	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 X Inpatie	nt 2 ER/O	utpatier	nt 3 DOA Oth	Or.			6 ∐Other (Spe	cify)	
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	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical C		Physician: To the best of aminer: On the basis of and manner sta	examination a								
	To th withir To th comp	Me	29b. Signature and title of certifier) -			29c. Licens	e number		29d. Da	te signed (Mont	h, Day, Year)	-
)	4		House X	nw	(MI)			D46346		Apı	ril 17,	2007	
p	v:DB NRS		30. Name and ddress of person who Huma Shakil,					rland, M	D 2150.	2			
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	Registr		APR 1 7 20	07	ar's Signature	A. a	int:						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 14:09 M 20 Samuel B. Bonsall, Jr. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Union Hospital Elkton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, AUG 3, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∭ M 2□ F Yrs 169-18-3551 85 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Ifem 27 is marked other than "natural" any injury or other traumatic accessing any injury or other accessing accessing any injury or other accessing accessing accessing accessing accessing accessing accessing accessing accessin 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Ceci1 Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 69 River View Avenue 21919 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? World 1 MYes 2 No 11 Hyes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Operator Oil Refining 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel B. Bonsall, Sr. Emma Fredericks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel B. Bonsall, III/Son 1006 Lafayette Blvd., Bowling Green, OH 43402 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State April 25, 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Media Cemetery Media, PA 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21921 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ca-diovascula-**Physician** Arterioscleratio disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 500 いナミハ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examine signed by the attending physicien and d be detached for use as the burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy performed 1 Yes 25 No To the Hospital or Attanding Physician: : After this certifical tuneral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident investigation 24 hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintened as success.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year)

April 24, 2007 29b. Signature and title of certifier 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Bruce Obenshain, 2515, Bohemia Ave, Cecilton, Md. 21913-0670 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 23 01:48 2007 James Leroy Bond /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford BEL ALL

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral №** M 2 🗆 F Director 207-26-2037 73 July 7, 1933 PA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Harford Pylesville MD 10g. Citizen of What Country? 10e. Street and Number 4901 St. Paul's Church Road 21132 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 🏖 No Specify: Completed by White 3 Widowed 4 Divorced natural traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) per it. Pages 1 and 2 should be filed within Der artment of Health and Mental Hygiene. Important: If item 27 Is marked other than "injury or other traumatic event, the Mecone. Elementary/Secondary (0-12) College (1-4or 5+) General Foreman Defense 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Everette Bond Elva Virginia White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet E. Bond/Wife 4901 St. Paul's Church Rd. Pylesville, MD 21132 20b. Place of Disposition (Name of St. Paul United Methodist Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Apr. 26, 2007 Pylesville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility J.J. Hartenstein Mortuary Inc. Mullal 6/11 19 S. Main St. Stewartstown, PA 17363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage End **Physician** 20 years disease or condition resulting in death) /Medical Due to (or as a consuluence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Mellitus 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a Was an 1□ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

certificate has Director: To the Hospital within 24 hours at To the Fune at E completely

72 hours after death with the Maryland

10 State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person

31. Date filed (Month, Day, Year,

Marco



completed cause of death (Item 23a) (Type, Print)

MD

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 22, Physician 2007 ROSS ELWOOD APRIL BITTNER 11:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CORRIGANVILLE ALLEGANY 11702 PROENTY ROAD If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV. 14,1918 9. Birthplace (State or Foreign **Funeral №** M 2□ F 220-10-7647 88 Director Yrs PENNSYLVANIA Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director MD ALLEGANY CORRIGANVILLE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itema 23a or 11702 PROENTY ROAD 21524 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours atter of Department of Health and Mental Hygiene.
Important: If item 27 le marked other than "natural", or Item any injury or other traumatic event, it is Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by Specify: 3 Widowed 4 ☐ Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 CHIEF TRAIN DISPATCHER RAILROAD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 EDGAR BITTNER CLARABELLE WRIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERALD BITTNER / SON 16600 VIRGINIA AVE., WILLIAMSPORT, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/25/2007 ST. JOHNS CEMETERY MEYERSDALE, PA 21. Signature of Funeral Service Licensee 22. MAFER FUNERAL SERVICE, P.A. 1302 NATIONAL HIGHWAY, LAVALE, MD 21502 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) **Physician** Dementa Advanced 6 months /Medical Due to (or as a consequence of): Examiner Schumbelly list and tions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical as the phys attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death P.O. F 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 dunknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No page 2 s certificete 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No i Director: / 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide o the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00055325 worselleller April 24, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48 Twen Terrace Frostburg MD21532 WONSOCK SHIN ND 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

		•	1- For State of Maryland / Dep	artment of Health and Mertificate of Death		ene 0 0 7	13769
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		John Walker Bailey, Jr.		April 2,	2007	1335 ^M
1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	<u> </u>		Harford Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Havre de Grace House 1 Year If Under 24 Hrs.	9 Date of Birth	Harford	lace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 63 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y 11/24/43	(ear) Coun	try)
			Usual Residence of Decedent				
	nylan ihow	_	10a. State 10b. County 10c. City, Town or L			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f s	cto	MD Harford Abero				
	with th	Dire	10e. Street and Number 3300 Churchville Road	10f. Zip Code 21001		i. Citizen of What Coun U.S.A.	try?
	eath v	Funeral Director				14. Race - Americ	an Indian,
(0	r iten	Fun	Armed Forces? 1 □ Never Married 2 ★ Married	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
21215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show Jisal Ezandar must be notified at	d by	1 Never Married 2000 No If Yes, Give- 3 Widowed 4 Divorced Year or Data Lietnam	1 ☐ Yes ŽŒNo Specify:		Specify: Whit	te
5-0	72 h "natu	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	sing 16	b. Kind of Business/Inc	dustry
12	within ane. then	dmo	Flementary/Secondary (0-12) College (1-4or 5+)	nanic		utomobile	
0	a filed within 7 al Hygiene. I other then "r vent, the west	o C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
<u>lan</u>	Ald ba	To Be	John W. Bailey, Sr.	Helen He	einz		
Maryland	and halls ma			ing Address (Street and Number or Run			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or items 23a or 28a-f show empty or other traumatic event, the Marked Examination in 100ce.			Churchville Rd.,			
Baltimore,	ages 1 or of H or of		1 (XBuria) 2 (Cremation 3 (Hemoval from State)	matory or other place)		c. Location - City or To	
Itim	iit. Partimer intent injury			Mem. Gdns. 4/5/		l Air, Mary	yland
Ba	permi Depa Impo eny ir		> KUSTEN HOUSE (MOS estros	2. Name and Address of Facility Tarring-Cargo Fune Aberdeen, Maryand	ralHome, 2 0 01-33	₽9 ^A •	
	2.		23a. Part1. Enter the disease, or complications that caused he death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician :		Immediate Cause (Final disease or condition	c Como Com			Onset and Death
	/Medical Examiner		resulting in death) Due (or as a consequence o):	ching can	CINOMO	•	
	Examine	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
7	tad nsit	nine	cause. Emer Underlying Cause (Disease or injury				
٦,	execu n and ial-tra	Examine	that initiated events c. Pue to (or as a consequence of):				
8760,	death certificate ba executad e attending physician and of for use as the burial-transit		d			10	
9	ertifica ing ph s as th	Med	IF FEMALE:				
Вох	that the death certific ed by the attending p detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy		23d. Date of delive Month	ery Day Year
0		ysic	1 Tes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)			
s, P.	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobac	cco use contribute to the	cause of death?
rds	iw requires that s been signed b should be det	ed b	Chronic Obstructive	Phlaonary Pis	1□Yes	2 ☐ No 3 Prob	ably 4 Dunknown
Vital Record		Completed			24a. Was an autopsy	24b. Were auto	psy findings available inpletion of cause of
Ä	: Tha law cate has b page 2 sl	Com			performe	death?	2110
/ita	ysicien: The is certificate director, pag	Be (25. Was case referred to medical examiner?		th (Check only one)		
of	Physicien: this certific ral director,	To.	1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2. ☐ ER/Outpatie		ome 5 Residence 28d. Describe how	ce 6 Other (Specify	1)
no	ding I h. After funer	tion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	20d. Doscribo now	injuly occurred	
Division	Atten r deat ector: by the	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura	l Route Number,
ā	tal or s afte el Dir	Certification:	4 Homicide building, etc. (Specify)		Only of Town, S	otate)	
	To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this of completely filled in by the funeral directs	edical	29a. Certifier (Check only (C				
	thin 2, the I the I the I the I the I	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month,	Day, Year)
6	Twin Solo	-	h Ch Ch MD	Diates	Δ	-Ox: 12	7007
			30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	/ (1)	17/	2100
	341		Marwe Lazatin M	D + Jan	1 > 1 W-	Mar	4)04/
	Sta	-	31. Date filed (Month, Day, Year) 2. Registrar's Signature	AN a	neen	/	7 10 100
	Registr	ar	APR 3 0 2007 July 15: 1903				

		1 - State Amend #2,PII, per Registrar 1. Decedent's Name (First, Middle, Last		719/0/	11 Cei	tificat	e of L	Death	2	Date of Deat		007	3. Time of	Death
Physicia		HAZEL J		DEN					7	Month PRIL	Day 20	07 Year	4:32	
/Medic Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o		** 11777		unty of Death	14.54	
LAMITHI	C 1	Holy Cross Ho				Si	lvei	Spi	ring		МО	NTGOM	ERY	
Funeral		Social Security Number 6. Se		ge (In yrs. la	ast birthday)	If Under	1 Year Days	If Under 2	24 Hrs. 8	Date of Birth	Year)	9. Birth	place (State of	r Fore
Director		213 30 3321	M 2√F	74	Yrs.	Wienting	Dayo	710413		(Month, Day, pr. 9	193	3 Was	sh. DO	3
* _	-	Usual Residence of Decedent 10a, State 10b, County		10c. City	, Town or Lo	cation				 -			10d. Inside Cit	ty Lim
f sho	ŏ	MD Montgo	merv		Si	lvei	r Sp	ring					1 ဩYes	2 🗆
28a-	Director	10e. Street and Number		1		10f. Zip				10	Og. Citizen	of What Cou	ntry?	_
3a or		717 Richmo	and Aver	nue				2091	.0		τ	J.S.A	•	
THE CHIEF	by Funeral	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S	S. 13. \	Nas Dece	dent of Hi	spanic Orig	gin? (Specif	y Yes or No- can, etc.)		Race - Ameri		
at FE	F	1 ☐ Never Married 250 Married	1 Yes 2			Yes			, rueno ra	Jan, etc.)		Black, White, ecify: B.	lack	
E		3 Widowed 4 Divorced	Year or Dates:	:										
last.	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)		16a. Deced	lent's Usua kind of wo	nk done d	ition Ju <i>ring most</i>	of working		16b. Kind o	of Business/In	dustry	
than	E D	Elementary/Secondary (0-12)	College (1-4or	5+)		louse					1	Home		
if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at		17. Father's Name (First, Middle, Last)							r's Name (F	First, Middle, N	faiden Sur	mame)		
ked c	To Be	Dewitt Marble	∍v. Sr						Sara	h Prio	ce			
mat m	-	19a. Informant's Name/Relationship (7)		sband	19b. Mailin	g Address	(Street a	nd Numbe	r or Rural F	Route Number,	City or To	wn, State, Zij	o Code)	
alth a		Maurice E. Bro	gden,Sr		717	7 Ric	chmo	nd A	ve.,	Silve	er Sy	pring	, MD 2	20
item othe		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Nar	ne of ther place	9)	Dat	θ 2	20c. Locati	ion - City or T	own, State	
not: if		1 Surial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	Geo	o. Was	shin	gton	Cem	1 4/1	7/07	Ade:	lphi,	MD	
Depertment of Health a importent: if Item 27 is any injury or other training.		21. Signatur of Funeral Service Lin ins	00	1.	/ 22	. Name an	d Addres	s of Facility	NONZ	DEN FU	JNEP	AL HO	ME P	
8 = 3		a young King	Duom	teu	1/2 2	46 N	. Wa	shin	gton	St,R	ockv.	ille,	MD 20	85
ysician and publician and strength and strength and the private transit	I Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to infine diale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Bila Due to (or as	irato irato teral s a consequ teral	pry Factorian Please of the property of the pr			usio	on					
hysic the b	dical		d. <u>Uros</u>	epsis	3									-
signed by the attending ph Id be deteched for use as ti	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pr Other (sp					23d.	Date of deliv	,	Year
ned b		Part II. Other significant conditions co	ntributing to death	but not resu	ilting in the ur	nderlying c	ause give	n in Part I.		23e. Did tob	acco use	contribute to t	he cause of d	leath
n sig	d by	Metastatic s	tage -	color	n can	cer				1 □ Ye	s 2□N	o 3□Pro	bably 4 🔀	Jnkn
as been si 2 should	Completed	Generalized	Anasaec	a- Ana	sarxa					24a. Was ar		4b. Were auto	opsy findings	avail
age 2	E									autops perform	nad?	death?	ompletion of ca	ause
rifica tor, p	a a	25. Was case referred to medical						26. Place	of Death (Check only one				
direc	10 B	examiner? 1 ☐ Yes 2√2 No	Hospital: 1 ⊠Inpat	ient 2 🗆 E	ER/Outpatien	t 3 DC	Othe			5 ☐ Reside		Other (Speci	fy)	
ter th	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury a <i>v Ye</i> ar)	28b. Time of	2	8c. Injury Work			d. Describe ho				
within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of In	ijury - At ho tc. (Specify	me, farm, stre	M eet, factory		/es 2□N		f. Location (Sti City or Town	reet and N , State)	umber or Rur	al Route Num	ber,
n 24 hours	edical C	29a. Certifier 1 🔀 Certifying Phy (Check only one)	sician: To the best ner: On the basis of and manner s	of examinati	wledge, death ion and/or inv	occurred estigation	at the tim , in my op	e, date and inion, deat	d place, and th occurred	d due to the ca at the time, da	use(s) and ate and pla	d manner as sice, and due t	stated. o the cause(s	;)
withly To 11 comp	Me	29b. Signature and title of certifier	1	0		290	c. License	number	,	29	od. Date si	gned (Month,	Day, Year)	
/		· W	apg	W			D64	189		6	14/1.	2/20	7-00	
											/			
3 D		30. Name and address of person who co	p et cause of	death (Item	23а) (Туре,	Print)				ver Sp		10		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 15° 2007 John Howard Burbage, Sr. 7:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9800 Coastal Hwy. Worcester 9. Birthplace (State or Foreign Country)
MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** ^{Year)} 16 **№** M 2 F Nov. 222-01-6488 90 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 TXYes 2 □ No Director MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9800 Coastal Hwv. 21842 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: White þ 3 □ Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Racetrack 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event John H. Burbage Minnie Isabelle Schorisch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9428 Stephen Decatur Hwy., Berlin, Md. 21811 John H. Burbage, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St.Paul's Churchyard 4-18-2007 4 Donation 5 DOther (Specify) Berlin, Md. 21. Signature of Fundal Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest in each line. P. rt1. Ent. th I dise ye, or complication the shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANDIGVASCULAST Onte loscupiano /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed WASETES Mellil and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 🗶 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29c. License number 046257 29d. Date signed (Month, Day, Year) 4-16-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDWIN CASTMENAKUD 10324 CUD OCEANLING RUW. BENLIN, KLD 2181 BA5+1 31. Date filed (Month, Day, Year)

State Registrar

APR 17 2007 32. Registrar's Signature

			1 - For State Registrar	State o	f Marylan		artment rtificate			nd Me		ieņe	1111/	13772
• · §	Physici /Medi		1. Decedent's Name <i>(First, Middle,</i> Evelyn	•	rbutus		Brow	n			Date of Deal Month April 1	Day	Year 2007	3. Time of Death 7:40 A M
	Examir		4a. Facility Name (If not institution, 114 Potomac St	-	mber)				ocation of	Death			County of Deat	h
	Funeral Director		214-52-1961	5. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 83	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, 06/04/1	Year) 923	Co	hplace (State or Foreign untry) t Virginia
	Aaryland I ehow	or	Usual Residence of Decedent 10a. State 10b. County MD A 1 1	egany	10c. Cit	y, Town or Lo	cation mberl	and						10d. Inside City Limits 1 X Yes 2 □ No
	with the h	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citi	zen of What Co	
	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "naturel", or iteme 23e or 28e-f show eumatic event, the Medical Exertrantal be redified at	Funeral	114 Potomac 11. Marital Status 1 Never Married 2 Marrie	12. Was Dec		.S. 13.	Was Deced f Yes, spec	215 lent of Hisp ify Cuban		in? (Speci Puerto Ri	fy Yes or No- can, etc.)		USA 14. Race - Ame Black, White	
21215-0036	'2 hours a	þ	3 Widowed 4 □ Divorced 15. Decedent's	ff Yes, Gi Year or D	ve 11	16a. Deced	1 ☐ Yes 2	Occupati	Specify:			16b. Kii	Specify: nd of Business/	White
2121	ed within 7 giene. er than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	kind of wor DO NOT us House	e retired)		of working		Pub	olic Sch	ools
Maryland	ould be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, La Henry		.more		Iman		8. Mother Alice		First, Middle, I	Ma <i>id</i> en	Sumame) Simmo	ns
Ž	and 2 sho ealth and n 27 is mu		19a. Informant's Name/Relationshi Gladys J. Sapp		er						Route Number Amberla		r Town, State, Z MD 21	(ip Code) 502
Baltimore,	Pages 1 nent of Hu ant: if iter ury or oth		20a. Method of Disposition 1		State	Place of Dispo cometery, crem nset Me	natory or ot	ther place)	rk 0½	Dat 4/18/			cation - City or mberland	
Balt	permit. Depertr importu eny inj		21. Signature of Fineral Service Li	Censee	1	22						•	Funeral and, MD	Home, P.A. 21502
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition	nty one cause on e	pused the death fach line.				_		espiratory arre	est,		Approximate Interval Between Onset and Death 2003
	/Medical Examiner		resulting in death) Sequentially list conditions,	b	(or as a conseq									
,0,	s be executed sicien and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	(or as a consequ									
68760,	rtificate bung physicias the bu	dedlcal	IF FEMALE:	d.										
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live b	tcome of pregna birth 2 Feta lant at time of di own	Ideath 3□	Ectopic pre Other (spe					2	23d. Date of deli Month	very Day Year
	w requires that been signed t should be det	by	Part II. Other significant condition	s contributing to d	eath but not res	ulting in the ur	nderlying ca	iuse given	in Part I.		23e. Did tob			the cause of death?
II Reco		Completed									24a. Was ar autops perform	y ned?	prior to death?	topsy findings available completion of cause of
Vita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Monitole							Check only on			
Division of Vital Records,	ng Phy fter this ineral d	tlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date (Mon	Inpatient 2 of Injury th, Day Year)	ER/Outpatien: 28b. Time of Injury		3c. Injury a Work?	4 Nurs	280	5 💢 Reside d. Describe ho		Other (Spec	erfy)
Divis	ial or Attendi s after death. al Director: A ed in by the fu	Certification;	3 Suicide 6 Could no determin	ad 286. Place	of Injury - At ho ng, etc. (Specify	ome, farm, stre	eet, factory,	office		28f	Location (Sti City or Town			ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	one)	Physician: To the aminer: On the b and man	best of my kno- asis of examina- ner stated.	wledge, death tion and/or inv	occurred a restigation,	at the time, in my opin	, date and lion, death	place, and occurred	d due to the ca at the time, da	use(s) ite and	and manner as place, and due	stated. to the cause(s)
)	With Tot C2 com	Σ	29b. Signature and title of contifier	-			29c.	D002			29		signed (Month	
	nes		30. Name and address of person with Qamar U.	Zaman, M	.D., 62	25 Kent		nue,	Cumbe	erlan	d, MD	215	502	
	Sta Registr	-	31. Date filed (Month, Day, Year) APR 1 7	2007	égistrar's Signa	ture	Was Miles							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 7 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** APRIL 21ST, 2007 16:56 Jerry R. Crouse /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)

WV Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1**X** M 2□ F Feb. 3, 1935 225-40-0263 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County r 28a-f show notified at 1 Yes 2 No Be Completed by Funeral Director Morgan Paw Paw 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code p o filed within 72 hours after death with r than "natural", or items 23a the Medical Examiner must b 25434 <u>USA</u> P.O. Box 281 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M 12 Glass Plant Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jerry N. Crouse Wilda Cannon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby S. Hogbin Crouse (wife) Paw Paw, WV P.O. Box 281 25434 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodrow Cemeterv Paw Paw, WV 21. Sig v un of Funeral Service Licensee 22. Name and Address of Facility McKee Funeral Home Inc. sta, WV 26704 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 270 Augusta, WV Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CURUNTY /Medical Due to (or as a conseque ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After the completely filled in by the funera 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred After 1 Natural

Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

SIDHU, HARJIT, M.D., 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
APR 3 0 2007

12690

APRIL 23 2007

			For State Registrar		of Marylai		ertment of tificate o		nd Me	ntal Hygie	ene 007	13774
ı	Physici /Medio		1. Decedent's Name (First, Middle Virginia	Last)	Bell	е	Clar	·k		Date of Death Month April 3.	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Town	, or Location of			4c. County of De	
			WMHS-Memori					berland				egany
	Funeral Director		216-18-1225	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 84	Yrs.	If Under 1 Ye Months Da		Min. 0	Date of Birth (Month, Day, Y)8/30/19	ear) 9. B 22 Oh	irthplace (State or Foreign Country) 10
	land		Usuat Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Mary I eh	ţŏ	MD Alle	egany		C111	mberlan	d				1 □XYes 2 □ No
	h the	Director	10e. Street and Number				10f. Zip Cod			10g	. Citizen of What C	Country?
	23a c	raic	701 Furnace S	Street, A	lpt. 223	3	21	502			USA	
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Itema 23a or 28e-f ehow aumatic event, the Medical Examinating must be indiffied at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 M Widowed 4 Divorced	Armed F	2 ⊠ No ive	H	Vas Decedent of Yes, specify C ☐ Yes 2∑1	of Hispanic Origi uban, Mexican, No Specify:	in? (Specif Puerto Ric	y Yes or No- an, etc.)	14. Race - Am Black, Wh Specify:	ite, etc.
20	72 ho	ted	15. Decedent' (Specify only highest	Education		16a. Deced	ent's Usual Oc	cupation	- f dei	16	b. Kind of Busines	White s/Industry
7	ithin	Completed	Elementary/Secondary (0-12)	T	1-4or 5+)	life. L	OO NOT use ret					
	filed w Hygier other th	Co	12	4		N	utritic	nal Aid			State Go	vernment
Maryland	should be find Mental His marked of	To Be	17. Father's Name (First, Middle, L Charles	ası)	Slo	naker		18. Mother Rut		First, Middle, Mai Naomi		Conway
Jar	is 1 and 2 should of Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationsh								ity or Town, State,	
	1 end 2 Health em 27 other tra		Ruth Keifer / 20a. Method of Disposition	Jaughter	20h	2300 Place of Dispos		Lane,	Cumbe		Maryland	
ğ	Pages nent of int: If it		1 Burial 2 Cremation		State	cemetery, crem	atory or other p	4			c. Location - City o	
altimore,	permit. Pages Depertment of Important: If it eny Injury or o		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L	**	Cui						umberlan	d, MD 1 Home, P.A.
ă	Ded of the part of		talut C	Jel-	2						and, MD	21502
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omptications that	caused the dea	th. Do not ente	r the mode of o	ying, such as ca	ardiac or re	espiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a(hourc	chs	Inche	Cu,	DIS	sein.		Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consec	(uence of):		J				1
		e	Sequentially tist conditions.	b. Due to	(Or as a consec	uença on.						
	d ansit	Examin	If any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	4		, .						
o	e exec en an irial-tr		resulting in death) Last	Due to	(or as a consec	uence of):						
8760,	icate be executed physicien and the burial-transit	dlcal		d								
Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐Live I 4 ☐ Pregi	tcome of pregnation of the community of	Ideath 3 🗌	Ectopic pregnar Other (specify)				23d. Date of de Month	elivery Day Year
0	at the by the	hys	9 Unknown	9□ Unkn								
Records, 1	requires that the	Þ	Part II. Other significant condition	s contributing to d	eath but not res	ulting in the un	derlying cause	given in Part I.				robably 4 Dunknown
ဝင္ပ	as be	plet								24a. Was an	24b. Were a	utopsy findings available
_	The law cete has page 2 s	Completed								autopsy performed	l? death? No 1 ☐ Ye	utopsy findings available completion of cause of
Vital		- 0	25. Was case referred to medical examiner?	Hospitat:			1,		of Death (C	heck only one)		
=	S S S	5	1 ☐ Yes 2 ☐ No 27. Mann of Death	28a. Date	Inpatient 2 🔀	ER/Outpatient 28b. Time of	3LI DOA			5 Residence	6 Other (Spe	ecify)
<u></u>	nding F ath. r: After e funer	at lor	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investiga	(Mon	th, Day Year)	Intury	28c. In W	ork? ☐ Yes 2 ☐ No		. Describe now r	injury occurred	
DIVISION	To the Hospitel or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 200. Place	of triury - At hing, etc. (Specif	ome, farm, stre	et, factory, offic	9	28f.	Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
	ne Hospil n 24 hour ne Funera	edical	29a. Certifier 1 \(\overline{\text{Certifying}}\) Certifying 2 \(\overline{\text{Medical E}}\)	tarrimer. On the b	best of my kno asis of examina ner stated.	wledge, death tion and/or inve	occurred at the estigation, in my	time, date and propinion, death	place, and occurred a	due to the cause at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the To the comp		29b. Signature and title of certifier		3	-	29c. Lice	nse number		1	Date signed (Mon	
1	2) (/h		2			766		A	pril 4,	2007
1	nas		30. Name and address of person w Vikramad					on Driv	re, Cu	ımberlan	d, MD 2	1502
	Stat		31. Date filed (Month, Day, Year)		egistrar's Signa							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 24^{Day} 2007 ear **Physician** 5:00 AM M Pearl Madora Dutrow */Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Citizens Care and Rehabilitation Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | April 7, Year 1906 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Maryland 1 M M F 217-10-0606 101 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Maryland Frederick Frederick YEYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 2508 Coach House Way, Unit 1B U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. Pages 1 and 2 should be filled within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itel 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No White Maryland 21215-0036 Specify: Specify: <u>م</u> 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Factory Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elmer Clayton Routzahn Madora Lee Stone ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank R. Young, son 2508 Coach House Way, Unit 1B, Frederick, MD 21702 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Financial International Intern 1 Burial 2 □ Cremation 3 □ Removal from State Zion Lutheran Cemetery Apr. 27, 2007 Middletown, MD 4 ☐ Donation 5 ☐ Other (Specify) ^{22 Name and Address of Facility} Keeney and Basford PA Funeral Home 106 East Church St., Frederick, M 21. Signatore of uneral Service License MO0255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner caroiorisula Anteroscherone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? of autopsy performed? 2 No 2□ No 1∏ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 2 No 1 ☐ Yes 3□ DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 2 28a. Date of Injury 28b. Time of 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation M 1 □ Yes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 1240307 April 24, 2007 asay 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene B. Casagrande M.D., 1564 Opossumtown Pike, Frederick, MD 21702 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Carried Services Registrar

			For State Registrar	State of Ma	•	epartmei Certifica				ental H		ene 0	07	13776
	Physici	an	1. Decedent's Name (First, Middle, La	st)						2. Date of I Month	Death	Day	Year	3. Time of Death
	/Medic		Harry Doye, Jr.							April	13			4:40 A M
	Examin	ier	4a. Facility Name (If not institution, giv				_	Location	of Death				ity of Death .ingto	
	.		218 St. Paul Stre		e (In yrs. last birt		ri Year	If Under	24 Hrs.	8. Date of I	3irth			plece (State or Foreign intry)
	Funeral Director			© M 2□F		Yrs. Months	Days	Hours	Min.	Feb.	Day, Y	^(ear) 1947	Mary	intry) land
3	2		Usual Residence of Decedent											
-	show	_	10a. State 10b. County		10c. City, Town									10d. Inside City Limits 1 ☐ Yes 2 ☐ No
4	28a-1	ecto	MD Washingto	on	Boonsbo		Code				100	Citizana	f What Cou	
deire	0 OL.	급	10e. Street and Number 218 St. Paul Stre	et		217	p Code 713				-	SA	WINAL COU	ante y r
4	lied within 72 hours arier dean with the maryland tal Hygiene. Ital Hygiene. do other than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Dece		spanic Ori	igin? (Spe	ecify Yes or			ace - Ameri	ican Indian,
,	in the	Fu	1 Never Married 2 Married	Armed Forces?		I				Rican, etc.)			lack, White	, etc.
	rai', c	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2121-NO	Specify:				Spec	Afr Afr	ican Americ
the country of the side of the same of the	natu	Completed	15. Decedent's En (Specify onfy highest gra	ducation de completed)	16a.	Decedent's Usi (Give kind of w	ork done a	luring mos	st of worki	ng	16	b. Kind of	Business/Ir	ndustry
i di	han.	m	Elementary/Secondary (0-12)	College (1-4or 5	(i+)	ille. DO NOT)			m.	rucki	na	
100	Hygie nt,	ပိ	17. Father's Name (First, Middle, Last,)	110	ICK DIIV	EI	18. Moth	er's Name	(First, Midd				
4	Sental Ked o	To Be	Harry Doye, Sr.]			y Dys				
	mari mari	۴	19a. Informant's Name/Relationship (Type, Print)	19b.	. Mailing Addres	s (Street a	ind Numb	er or Rura	I Route Nur	nber, (City or Tow	m, State, Zi	ip Code)
5	alth a 27 io		Saprena L. DeAnge	elo/daught	er 37	705 Hope	Com	mons	Circ	le Fre	ede:	rick,	MD 2	1704
	item item		20a. Method of Disposition		20b. Place of	Disposition (Na y, crematory or	me of			Date			n - City or T	
a	nent of the		1 ☐ Burial 2 【ACremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			eake Cı			04/1	6/07	В	eltsv	ille,	MD
Port Bacos 1	permitter gages i and 2 should be fled within 12 hours aren dean with the marylan beperture in the fled with the Mantal Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified at QDCs.		21. Signature of Funeral Service Lice	For dutte	MO1251	22. Name a	nd Addres	s of Facili	ity		Xic	e Clark	O. Bo svill	ž, ⁷⁸⁴ 21029
	hysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each ling	the death. Do no.	not enter the mo	_	g, such as			arres	t,		Approximate Interval Between Onset and Death
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giji	ing phy		IF FEMALE:	=										
set the death contific		Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐Ectopic 5 ☐ Other (s					-		Date of delive Month	very Day Year
	been signed by the a should be detached to	ě	Part II. Dther significant conditions	contributing to death b	ut not resulting in	the underlying	cause give	en in Part I	l.	1		cco use co		the cause of death?
or Attending Physician: The law requires #	nis certificate has been	Completed								24a. W au pe 1 □ Ye:	itopsy informe	24l	death?	topsy findings available ompletion of cause of
e i	ector,	Be	25. Was case referred to medical examiner?	11			01			(Check on				
Phys	this cal dire	ဥ	1 ☐ Yes 2 No 27. Manner of Death		ent 2 ER/Ou					me 5 Re 28d. Describ				ufy)
dip	th. After thi funeral	ion	1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 280. I	Time of njury M	28c. Injury Work	γαι (? Yes 2□	1	28d. Descrit	39 HOW	r injury occ	unea	
- 5		Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of Inj	ury - At home, fa c. (Specify)					28f. Location City or			mber or Rui	ral Route Number,
a Hospita	within 24 hours after deat To the Funeral Director: completely filled in by the	edicai C	29ta Curtifier 1X Certifying Pl (Check only 2 Medical Example)	nysiciam: To the best miner: On the basis o and manner st	of my knowledge f examination an ated.	e Jeath scrume d/or investigation	d at the tin n, in my op	a Jata a pinion, dea	nd place; ath occurr	and due to t ed at the tim	ha cau ne, dat	isa(s) and e and plac	manner as e, and due	stated to the cause(s)
Total	within To the	Me	29b. Signature and title of certifier	D		2:	C. License	9 number	7/		290	_	ned (<i>Month</i>	Day, Year)
ع)	ad		30. Name and address of person who	completed cause of c	death (Item 23a)	(Type, Print)	TOLL	lA	tous	e Ar	e_			ch my
Ē	Sta Registr		31. Date filed (Month, Day, Year) APR 16	Zaidi 1 2007 32. Redistr	rar's Signature	Spark	e							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year Physician CHARLES Ε. DISMUKE 428 M 2007 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PALISBURY ENTER heamico ENINSULA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**X** M 2□F 222-30-9433 JUL 07, SELBYVILLE, DE Director 1949 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at SUSSEX COUNTY DELAWARE FRANKFORD 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number SHOCKLEY 22 DRIVE 19945 UNITED STATES Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1970-71 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: BLACK \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Is marked other than DISTRICT MANAGER **INSURANCE AGENCY** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLIE DISMUKE GERALDINE MITCHELL မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDREA H. DISMUKE (SPOUSE) 22 SHOCKLEY DRIVE, FRANKFORD, DE 19945 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town. State permit. Pages 1 Department of H Important: If Ite any Injury or ot DELAWARE VET. CEM. 4 Donation 5 ☐ Other (Specify) APR 19,2007 MILLSBORO, DELAWARE 21. Signature of Funeral Service Li Name and Address of Facility WATSON FUNERAL HOME MO 1361 MILLSBORO, DELAWARE 19966 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Allmoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed Hypertension Due to (dr as a consequence of): physician ar s the burial-t Box 68760 Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) o. the 9☐Unknown 9 Unknown signed by t ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA ဥ After this 27. Ma of Death uneral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? (Month, Day Year Division Hospital or Attending Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

BA6+1

State Registrar

31. Date filed (Month, Day, Year) APR 17 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MILFORDST

29c. License number

29d. Date signed (Month, Day, Year)

David Frost		- For State	of Maryland / D	epartment o		d Mental			208	7 13778
Physicia		tegistrar 1. Decedent's Name (First, Middle,La					2. Date of Dea			3: Time of Death
Medical Examin		David	F	rost			Month April 22,		Year	-0937 hrs
		4a. Facility Name (if not institution, gi Fort Washington Hospita			4b. City, Town, or I Fort Washin		eath		County of Dear	
Funeral		5. Social Security Number 6. S		ı yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of B	irth(MM/D		
Sirector		577-92-5626	X _{M 2} F 40	Yı	Months Days	Hours I	Min. Feb.	21,	1967 c	ounty DC
	1	Usual Residence of Decedent								
w any		10a. State 10b. County	1	City, Town or Loca						10d. Inside City Limits 1 Yes 2 X No
yland -f sho	ģ	Maryland Prince	George's	For	t Washing	gton		10a Citiza	en of What Co	
r death with the Maryland or items 23a or 28a-f show must be notified at one.	Director	5439 Haras Place			20744	'.	Ĭ	rog. Oniz	U.S	
vith th	ह	11. Marital Status	12. Was Decedent Eve	er in U.S. 13. W	as Decedent of His		(Specify Yes or N	0- 1	14 Race - Ame	rican Indian Black
eath v	Fune	1 Never Married 2 X Marrie	d Armed Forces?		Yes, specify Cuban	, Mexican, Pue	erto Rican, etc.)		White, etc.	frican
after d	by F	3 Widowed 4 Divorce	d If Yes, Give Year	1	Yes 2 X No	specify:			Specify: A	merican
hours		15. Decedent's Education (Specify			ent's Usual Occupati most of working life.			L	nd of Business	
36 in 72 han " dical	Bet	Elementary/Secondary (0-12)	College (1-4 or 5+)	Stock	clerk Te	pachar		waı	Mart/	Lexus Child Care
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Completed	17. Father's Name (First, Middle, Las		DLOCK			ame (First, Middle,	Maiden S	Surname)	Gare
215 oe file ntal Hy ked o	Be	Franklin	Frost				Oorothy		att	
21 hould I hould I is mar	의	19a. Informant's Name/Relationship			ng Address (Stree					
MD nd 2 sho alth and m 27 is		Claudia Frost (W 20a. Method of Disposition	ife)		Haras Pl				, Maryl	and 20744
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at ones.		1 X Burial 2 Cremation 3	Removal from State	crematory or	other place)		pril 27,			
timent trant:		4 Donation 5 Other Special 21. Signature uneral Serv	у.	Harmony M	Name and Address		2007			, Maryland
Bal permi Depar Impo		21. Signature uneral Serv	MO14	////						on, MD 20735
Physician		23a. Part I. Enter the direase, or con								Approximate Interval Between Onset and
/Medical		failure. List only one cause on a Immediate Cause (Final disease	each line. a. Sepsis with	complication	ons					Death Death
Examiner		or condition resulting in death)	Due to (or as a conseque	ence of):						
A 194	<u>_</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	pacemaker <u>s</u>	ite		*			
	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated	Dae to (or as a senseque							
isi ed C	Exai	events resulting in death) Last	Due to (or as a conseque	ence of):						
be executed sician and unrial - transit	dical	UNPENDED	AMENDED:	07 147	060 6/1/07					
- o o o	/edi	IF FEMALE:	#23a-b,PII,		868, 6/1/0/	TT		23d	. Date of delive	ery
n of Vital Records, P.O. Box 68760 ing Physician: The law requires that the death certificate there this certificate has been signed by the attending physituneral director, page 2 should be detached for use as the broaden	- 	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 F	etal death 3	Ectopic pre	egnancy	1000	Month	Day Year
Box (e death of the attended for us	Physicia	1 Yes 2 No 9 Unknow	vn 4 Pregnant at time	e of death 5	Other (Specify)					
O. B. nat the d id by the		Part II. Other significant conditions		ut not resulting in the	underlying cause g	given in Part I.	23e. Did	tobacco u	use contribute t	o the cause of death?
P.(d by	Hypertensive at	nerosclerotic c	ardiovascul	ar disease		1 Y	es 2	No 3 Pr	obably 4 🗸 Unknown
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should	Completed						24a. Wa auto	s an opsy		autopsy findings available completion of cause of
eco he law tte has	Jup						per	ormed?	death?	
an: T ertifice tor, pa	രം	25. Was case referred to medical			26.Place	of Death (Ch	eck only one)			
Vita hysicia this ce	O B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 CR/Outpatie			ursing Home 5	Resider		er:
n of V ding Phr. After tl funeral	nc:	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o		ry at Work?	28d. Describe	e how inju	ry occurred	
ivisior I or Attend after death Director:	atic	2 Accident 5 Pending	ation			Yes 2 No		(Charat as	and Nillian and and	Dural Davita Number City
Division Spital or Attendifunces after death. meral Director: A	Certification:	3 Suicide 6 Could no determin	ot be	/ - At home, farm, sti	eet, ractory, office b	ouliding, etc.	or Town,		id Number or i	Rural Route Number, City
E E E E		29a. Certifier	ician: To the best of my kr	nowledge, death occ	urred at the time, da	ate and place.	and due to the ca	use(s) and	d manner as st	ated.
To the Hos within 24 h To the Fur	Medical	Check only	er: On the basis of examination and manner stated.							
T	Me	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	<u> </u>	29d. E	Date signed (N	fonth, Day, Year)
		Cal 2	01	()	O.C.	M.E.		April	23, 2007	
		30. Name and address of person wh	· ·				04054	-	_	
Ø			sistant Medical Exar	Cinneture	enn Street, Balt	imore, MD	21201			
Si Regis	tate trar	31. Date filed (Month Pay Year) 20	32. Registrar's	Signature	de					
Incegio	التعد		Al - wheeler							

15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 17b. Father's Name (First, Middle, Last) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)	thplace Signar in untry) Virginia 10d Inside City Limits 1 Yes 2 XNo attry? can Indian, Black, nite ndustry
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Route 67 at Brownsville Road 5. Social Security Number 217-58-3786 1 M 2xF 55 Yrs. 4b. City, Town, or Location of Death Brownsville 4c. County of Death Washington 4d. County of Death Washington 4c. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington 5. Social Security Number 217-58-3786 1 M 2xF 55 Yrs. 4d. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington 4d. County of Death Washington	thplace Seator in untry) Virginia 10d Inside City Limits 1 Yes 2 XNo entry? can Indian, Black, nite ndustry
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Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d Inside City Limits 1 Yes 2 No ntry? can Indian, Black, nite ndustry
10a. State 10b. County 10c. City, Town or Location	1 Yes 2 XNo ntry? can Indian, Black, nite ndustry
MD Frederick Burkittsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Cour 10g. Citizen of	can Indian, Black, nite ndustry
The street and Number of Stree	can Indian, Black nite ndustry
11. Marital Status 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 1 Never Married 2 X Married 1 Never Married 2 X No specify: 1 Yes 2 X No specify: 1 No specif	nite
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The surface of the state of the	ndustry
9 Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Paul A. Fowler Sr. 18. Mother's Name (First, Middle, Maiden Surname) Paul A. Fowler Sr.	
See the state government of th	/'t.
18. Mother's Name (First, Middle, Maiden Surname) Paul A. Fowler Sr. 18. Mother's Name (First, Middle, Maiden Surname) Betty Jane Portmess	
N 9 3 2 E M	
Paul A. Fowler Sr. Betty Jane Portmess 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Paul A. Fowler Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Co. Phys. Street and Number or Rural Route Number, City or Town, State, Co. Phys. Street and Number or Rural Route Number, City or Town, State, Co. Phys. Street and Number or Rural Route Number, City or Town, State, Co. Phys. Street and Number or Rural Route Number, City or Town, State, Co. Phys. Street and Number or Rural Route Number, City or Town, State, Co. Phys. Street and Number or Rural Route Number, City or Town, State, Co. Phys. Street and Number or Rural Route Number, City or Town, State, Co. Phys. Street and Number or Rural Route Number, City or Town, State, Co. Phys. Street and Number or Rural Route Number, City or Town, State, Co. Phys. Street and Number or Rural Route Number, City or Town, State, Co. Phys. Street and Number or Rural Route Number, City or Town, State, Co. Phys. Street and Number or Rural Route Number, City or Town, State, Co. Phys. Street and Number or Rural Route Number, City or Town, State, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rural Route Number, Co. Phys. Street and Number or Rur	Zip Code 2 1 7 1 8
Paul A. Fowler Sr. Betty Jane Portmess Paul A. Fowler Sr. Betty Jane Portmess 19a. Informant's Name/Relationship (Type, Print) Ralph E. Fawley (Husband) 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City of cemeter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City of cemeter)	le, MD
20a. Method of Disposition 1	
Union cemetery 4/18/200 Burkittsv	•
22Dona 16 Far Thompson Funeral Hompson P. O. Box 18, Middletown, MD	ne 21769
Physician 23a. Part I. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and
Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Chest Due to (or as a consequence of):	Death
Sequentially list conditions, b	
if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	-
UNPENDED AMENDED UNPENDED AMENDED FF FEMALE: 23d. Date of delivery	
Yes 2 No 9 V Unknown Second Program of Second	ay Year
23b. Was decedent pregnant in the past 12 months? 1	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
The law we do not be a sign of the law with law with the law with the law with the law with the law with the	
24a. Was an autopsy performed? 1	opsy findings available ompletion of cause of
Definition of the periodine of the peri	2 No
25. Was case referred to medical examiner? 1 Ves 2 No 25. Was case referred to medical examiner? 1 Ves 2 No 1 DOA 26. Place of Death (Check only one) Control of Death (Check only one) Control of Death (Check only one)	Scene
25. Was case referred to medical examiner? 1 Ves 2 No 25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) 27. Manner of Death 28b. Date of Injury 28b. Time of Injury 28b. Ti	
The state of the s	
Company of the part of the par	
so of the state of	
e is e to be and manner stated.	
29b. Signature and title of certifier 29c. License number O.C. M.E. April 15, 2007	h, Day, Year)
30. Name and address of person who completed cause of death (Item 23a)	
Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 7 2007 32. Resistrar's Signature (State Registrar	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Certifica	ent of nearth and Mental Hy ate of Death	Reg. No.	17 1378
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
edical Examiner	CHAILER 1. CLIBELE	Lu Cir Tura es la sella est Docth	Month Day Year April 18, 2007	1900 hrs
	Facility Name (if not institution, give street and number) To North Bridge Street	4b. City, Town, or Location of Death Elkton	Cecil	"
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24Hrs.		rthplace (State or
Director	180-12-0376	Yrs. Months Days Hours Min.	NOV 17, 1922	grPennsy1vani ountry)
aux	10a, State 10b. County 10c. City, Town of	or Location		10d. Inside City Limits
Maryland 28a-f show any datonce, rector	Maryland Cecil Elkt			1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	·
ith the last the last the last the last the last the last the last the last the last the last the last the last the last last last last last last last last		21921 13. Was Decedent of Hispanic Origin? (Sp	United S	rican Indian, Black,
or items 23 must be no	1 Never Married 2 Married 1 X Yes 2 No T	If Yes, specify Cuban, Mexican, Puerto		
safter d		1 Yes 2 X No specify:		ite
hours Frami ed t		Decedent's Usual Occupation (Give kind of watering most of working life. DO NOT use retire		•
OO36 within 72 hour giene. her than "natu her than bedical Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	Forklift Operator	Manufactu	
5-00 ed wit dygien other the Me	17. Father's Name (First, Middle, Last) unknown			nknown
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		. Mailing Address (Street and Number or F	Charles Name City of Town Charles	a Zin Codo)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	, , , , , ,	0. Mailing Address (Street and Number of F 1945 Lasher Road, Dre	· ·	
e, N	20a, Method of Disposition 20b. Place of	f Disposition (Name of cemetery,	Date 20c. Location - City of	
Baltimore, permit. Pages 1 ar Department of Hor Important: If ite	1 X Burial 2 Cremation 3 Removal from State T cremat 4 Donation 5 Other Specify:	ory or other place) Late Conception April 200	Cherry Hi	11. MD
Caltin	21. St nature of Funeral Service Licensee	22 Name and Address of Facility Hicks Home for Fund 103 W. Stockton St		
	23a. Part I. Enter the disease, or complications that caused the death. Do no	103 W. Stockton St	reet, Elkton, MD 2	21921 Approximate Interval
Physician /Medical	failure. List only one cause on each line.		, , , , , , , , , , , , , , , , , , , ,	Between Onset and Death
aminer	Immediate Cause (Final disease or condition resulting in death) a. Attrefoscierotic Cardiovascu Due to (or as a consequence of):	di Discuso		
<u> </u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
ed sit	cause. Enter Underlying Cause (Disease or injury that initiated			
Exa	events resulting in death) Last d. Due to (or as a consequence of):			
). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transi Physician/Medical Ex	UNPENDED AMENDED			
760, icate by physic the bun	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	Fetal death 3 Ectopic pregna	23d. Date of deliverancy Month	ery Day Year
Box 687 death certific the attending p dof for use as th	past 12 months? 1 Live birth 2 4 Pregnant at time of death		ancy Worth	Day
Bo ne deat the at hed for	1 Yes 2 No 9 Unknown g Unknown	in the condestries serves given in Dest I	23e. Did tobacco use contribute	o the cause of death?
i, P.O. B res that the d signed by the detached by the detached by Phy	Chronic alcoholism	g in the underlying cause given in Fart i.	1 Yes 2 No 3 Pr	
cords, F aw requires has been sign 2 should be				autopsy findings available completion of cause of
Records, The law requires, ficate has been significate has been significate has been significate has been significate has been significate has been significated by the significant sign			autopsy prior to death?	,
tal Reco		26.Place of Death (Check		
F Vital Physician r this certi al directo	1 ✓ Yes 2 No 1 Inpatient 2 ER/O		ng Home 5 Residence 6 🗸 Ott	ner: Scene
ding Pl		Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
Division of Vital Records, tal or Attending Physician: The law requir as a fair cleah. The rate return the fine to retuit car the funeral director, page 2 should be reflication: To Be Completed.	Pending Accident Investigation 28e. Place of Injury - At home, fa	arm, street, factory, office building, etc.	28f. Location (Street and Number or	Rural Route Number, City
Division o spital or Attending rours after death. neral Director: After filled in by the function.	3 Suicide 6 Could not be determined (Specify)	,. <u> </u>	or Town, State)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Directors. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burither all certification. To Re Completed by Physician/Med		ath occurred at the time, date and place, and nvestigation, in my opinion, death occurred	d due to the cause(s) and manner as si at the time, date and place, and due to	ated. the cause(s)
To Too	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (A	nonth, Day, Year)
	Sarlie Jeeg mp	O.C.M.E.	April 19, 2007	
141	30. Name and address of person who completed cluse of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner	111 Penn Street, Baltimore, M	D 21201	
Stat Registra	77 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Carle		
DHMH 17 Rev 1/2001	0	RIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Mary /Medical 07 0505 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WMHS Braddock Campus Cumber land Allegany if Under 1 Year | if Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 215-24-1498 **Funeral** Months Days 1 □ M 2 🗓 F 83 1923 Director DEC 24, Virgínia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits at r 28a-f sh notified Director 1 Yes 2 No WV Mineral Ft. Ashby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or USA 26719 Dawn View Nursing Center Funeral 12. Was Decedent Ever in U.S. Armed Forces? r than "natural", or items the Medical Examiner ma Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 💥 No Specify: White Specify. ģ 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry lith and Mental Hygiene. 27 is marked other than " r traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Carrie Haggerty William Amos Shoemaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 Is or other train PO Box 933, Moorefield, WV 26836 Shirley Crites Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once, Apr 28 07 4 ☐ Donation 5 ☐ Other (Specify) Greenhill Cemetery Old Fields, WV 22. Name and Address of Facility Hafer Funeral Service, PA 21. Signature of Fugeral Service Licenses 1302 National Hwy., LaVale, MD 23a. Part 1/Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NTRACRANIAL APRIL 20 /Medical Due to (or as a consequence of). 2007 Examiner Sequentially list conditions, any terms of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4. 2 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? Yes 2/2 No certificate fo the Hospital or Attending Physician: 24 hours after death. E Funeral Director: After this certific letely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗹 Inpatient မ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

Date filed (Month, Day, Year)

Zaman

2007

DHMH 17 Rev 1/2001

within 2

Kent

29c. License number

29d. Date signed (Month, Day, Year)

Avenue Cumberland Haryland 2502

and manner stated.

ess of person who completed cause of death (Item 23a) (Type, Print)

625

gistrar's Signature

			State of Maryland / D	epartment of Health a			200	1 13782			
			Registrar 1. Decedent's Name (First, Middle, Last)			Date of Death		3. Time of Death			
п	Physicia /Medic		JACOB HAMILTON		AI	Month PRIL	Day Year 200	7 21:29 M			
į.	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	of Death		4c. County of Dea	uth			
100		Щ	MEMORIAL HOSPITAL	CUMBERLAND			ALLEGANY				
G.	Funeral Director		703-07-9010 / 83	nday) If Under 1 Year If Under	r 24 Hrs. 8. Min.	Date of Birth (Month, Day, VOV 4,	^{Yea} r) 9. Bli 1 923	thplace (State or Foreign ountry) VA			
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits			
	Maryl f sho	to	WV Mineral V	Viley Ford				1 □ Yes 2 □ No			
	r 28a notif	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of What C	ountry?			
	th wit	al D	P.O. Box 205	2676	67		USA				
	tems terms	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexical	rigin? (Specit an, Puerto Ric	y Yes or No- can, etc.)	14. Race - Am Black, Whi				
36	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show wit, the Medical Examiner must be notified at	by Fi	1 ☑ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII	1 ☐ Yes 2 ☐ X o Specify:	<i>'</i> :		Specify:	hite			
ဒို	hour tural		15. Decedent's Education 16a. I	Decedent's Usual Occupation		1	6b. Kind of Business				
215	nin 72 s. In "na Medic	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during mos life. DO NOT use retired)	st of working			,			
21	ed with	Completed	12 Pip	pefitter			CSX Railro	oad			
D D	be filk d oth d oth event	Be	17. Father's Name (First, Middle, Last)				aiden Surname)	•			
$\frac{2}{3}$	d Mer narke	٦	Jacob Bernard Hamilton				n) Hamilton	1			
, Mai	and 2 st ealth and n 27 Is r		19a. Informant's Name/Relationship (Type. Print) Doris Baker cousin	Mailing Address (Street and Numb 704 Medway Road	d d		rstown	MD 21740			
Baltimore, Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heath and Mental hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show yr other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at		1 Deural 2 Compation 2 Deproval from State Cemeters	Disposition (Name of crematory or other place) by Cemetery	Date 4/2	26/2007 2	Oc. Location - City of Fort Ashk				
Salti	permit. Page Department Important: If any Injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facili Scarpelli Fune				· · · · · · · · · · · · · · · · · · ·			
	80 = 60		23a. Parti. Enter the disease, or complications that caused the death. Do no	108 Virginia Av				Approximate			
			shock, or heart failure. List only one cause on each line.			copilatory arres	J.,	Interval Between Onset and Death			
	Physician /Medical		disease of condition resulting in death) INFILTRATING CARCINOMA OF THE COLON Due to (or as a consequence of):								
	Examiner	ner		.,.							
ļ	36.		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	f):							
Ş	ecutec nd transi	Examiner	that initiated events C.								
8760,	cate be executed oblysician and the burial-transit		resulting in death) Last Due to (or as a consequence o	f):							
	physic the b	dical	d								
X S	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy				23d. Date of de	aliven			
ROX	death atter	ciar	250. Was decedent pregnant in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year			
j.	ires that the de signed by the a be detached f	hysi	9 ☐ Unknown 9 ☐ Unknown								
ρ, J	requires that the een signed by the rould be detache	by P		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
g	w require been sign	pel	HISTORY OF RENAL CELL CANCER HEALED	BY NEPHRECTOMY,		1 ☐ Yes	s 2 No 3 F	robably 4 □Unknown			
Vital Records,	law as b 2 st	Completed	PULMONARY EMBOLISM, ATRIAL ARRYTHMI	Α		24a, Was an autopsy	prior to	utopsy findings available completion of cause of			
E E	ate pag	Con				perform 1□ Yes 2	ed? death? XNo 1 ☐ Ye	s 2□No			
Ž Ž	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	0.45		Check only one					
Ö	Phys this ral dir	. To	1 ☐ Yes 2 ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐				nce 6 Other (Spenior occurred)	ecify)			
0	Attending Physician: r death. ector: After this certific by the funeral director,	tion		me of 28c. Injury at york? M 1 Yes 2		2. Describe nov	willigary occurred				
DIVISION	or Attendiater death. Director: A	fica	3 Suicide 6 Could not be	m, street, factory, office	28f		eet and Number or F	Rural Route Number,			
5	ipital or Atonics after of the properties of the	Certification:	4 Homicide determined building, etc. (Specify)			City or Town,	State)				
	Hos 14 hc Fun Fun tely	edical (29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and/or investigation, in my opinion, dea	and place, and eath occurred	d due to the ca at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)			
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number		29	d. Dete signed (Mon	th, Day, Year)			
			I	D19318		A	PRIL 23, 20	007			
	5		30. Name and address of person who completed cause of death (Item 23a) (TRANJITHAN, N.A., M.D. 517 OLDTOWN		O, MD 2	21502					
	Sta				-						
	Registr	ar	31. Date filed (Month, Day, Year) APR 3 0 2007 Registrar's Signature	passe							

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	otato of marylan	•	tificate of l			Reg. No	2007	137	183		
	Physici		1. Decedent's Name (First, Middle, Las Angela Sue Hendr					2. Date of De		^y 2007 ^{Year}	3. Time of 9:00	Death A M		
	/Medic Examin	al	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death Germantown				4c. County of Death Montgomery					
	Funeral Director		5. Social Security Number 529-33-9269 6. Sr	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan. 28	av Year) Couin		r Foreign					
the Maryland 28a-f show	the Maryland 28a-f show	rector	Usual Residence of Decedent 10a. State Maryland 10b. County Montgome 10e. Street and Number		mantov				10g. Ci	tizen of What Coun	0d. Inside Cit 1 ☐ Yes try?			
	th with 23a or sst be r	al Di	11108 Sceptre Rid	ge Terrace		2087	6		-	ted State				
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 X No if Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify:			14. Race - Americ Black, White, Specify: Wh					
15-0	n 72 hc "natul edical	Completed by	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	king	16b. k	Kind of Business/Ind	dustry			
212	d withii giene. er than the M	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		lone	·]	None				
and	be file ntal Hy od othe event,	Be	17. Father's Name (First, Middle, Last) Kenneth Lee Allen				18. Mother's Nam Kelly St			n Surname)				
Maryla	d 2 should th and Mer 7 is marke traumatic	욘	19a. Informant's Name/Relationship (1	•	and Number or Ru	ıral Route Numb	ber, City	or Town, State, Zip mantown ,		 376		
Baltimore, Maryland 21215-0036	Pages 1 an ent of Heal nt: If item 2 y or other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Removal from State Ne	lace of Dispo emetery, crei elsvil	osition (Name of matory or other place le Presby emetery	Apri 20	Date 14,	l .	ocation - City or To	_	and		
Baltir	permit. F Departme Importan any Injur		21. Signature of Funeral Service licen	/ / /	22	2. Name and Addre	ss of Facility De	Vol Fune		Home, 10				
	Physician /Medical		23a. Part1. Enter the disease, or com shock/or leant fature. List only Imme the all (Final disease or condition resulting in death)	a. Huntington'	s Dise	ter the mode of dyir					Approximate Interval Bet Onset and I	ween Death		
	Examiner			Dysphagia	Due to (or as a consequence of): Dysphagia 3 months						ns			
	ed sit	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	Due to (or as a consequence of):									
68760,	death certificate be executed e attending physician and ed for use as the burial-transit	al Examiner	that initiated events resulting in death) Last	CDue to (or as a consequent	uence of):									
	tificate ng phys as the	Medical		d			-							
P.O. Box	that the death cer ned by the attendin detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🏝 Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3[□Ectopic pregnancy □ Other <i>(specify)</i> _	у			23d. Date of delive Month		Year		
	56 JG 96	ρ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.			use contribute to tl 2ᡌNo 3☐ Prot				
Division or Vital Records,	The ate has page	Completed						24a. Was auto perl 1 Yes	opsy form <u>ed</u> ?	24b. Were autoprior to codeath?	psy findings mpletion of c 2 \square No	available ause of		
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	The reliab										
on or	iding Phys h. After this funeral di	ion: To	 	, I	1 🕅 Yes 2 □ No 27. Manner of Death 1 🕅 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Injur	4 LI Nursing F	28d. Describe		6 ☐Other (Specification occurred)	ý)	
Division or Attending	al or Atter after deat Director d in by the	Certification:	3 Suicide 6 Could not be determined	Zoe. Flace of injury - At he	Be. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location City or To	cation (Street and Number or Rural Route Number, ty or Town, State)		nber,			
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	edical C		ysician: To the best of my kno niner: On the basis of examina and manner stated.								s)		
	To the within 2 To the	Me	29b. Signature and title of certifier	\ N		29c. Licens				ate signed (Month,				
	3		30. Name and address of person who	TV IVW	n 23a) /Tuna	D403	53		Apr	i 1 12, 20	007			
			James Yan, M.D. 1	•			ockville	, MD 208	852					
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 6 20	32 Registrar's Signa		anti)								

10

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 3 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. Harnt Si DHV 925 Bishop Walsh Road Comberland, Nd. 21502

29c. License number

D16907

29d. Date signed (Month, Day, Year) APRIL 242007

Registrar DHMH 17 Rev 1/2001

MR

State

M.D.

Didhu

31. Date filed (Month, Day, Year)

925

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Charles G. Kosonen 13 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOLISBURY Momile PONINSULA Medica If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 3, 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 X M 2 □ 566-32-1173 California Dec. 1927 Director 79 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2\no Director MD Ocean Pines Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 36 Grand Port Rd. 21811 US Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Naval Architect U.S. Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (George Kosonen Sadie Wilpone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 36 Grand Port Rd., Ocean Piens, Md. 21811 Gracelene Kosonen (wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 4-16-2007 Frankford, DE 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 23a Part 1. Enter the discussion on each line.

108 William St., Berlin, Md.

23a Part 1. Enter the discussion as complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 William St., Berlin, Md. 21811 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2515 /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed bel burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 ☐ Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ...
autopsy
performed?

ves 2 2 No page 2 has Fi After this certificate La Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28b. Time of 28c. Injury at Work? 27. Mapner of Death 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

BA 20+1

State Registrar Jettrey vy.
31. Date filed (Month, Day, Year)
APR 17

elano

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salisbury, md, 21801 100 E. Carroll St. 32. Registrar's Signature

D34768

April 13, 2001

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be ပ

Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar

	Pleas					c. Ensure A		•	
For Stete Registrar		State	ı ıvıaryıa		ertificate of	Health and N Death	, ,	ene 1. No. 2 A A '	7 12727
Decedent's Name	e (First, Middle,	Last)					2. Date of Death	LUU	3. Time of Death
Elizabe	th F	R. Lou	ro				Month April	Day Yea 200	LA LA
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death									
Holy Cross Hospital Silver Spring Montgome								mery	
5. Social Security N	lumber	6. Sex	7. Age (In yrs	s. last birthday) If Under 1 Yea Months Days		8. Date of Birth (Month, Day,)	(ear) 9. B	Sirthplace (State or Foreign Country)
215-80-3		1 M 2 1 F	46	Yrs.			Nov. 19,		aryĺand
Usual Residence of 10a. State	Decedent 10b. County		10c. C	City, Town or L	ocation				10d. Inside City Limits
	,								1 ☐ Yes 2 🔀 No
Maryland 10e. Street and Nur	Frede	erick		Ne	W Market		100	g. Citizen of What (Country?
		0.14 11			Zip oode	21774	100		
	wnite F	Pelican W	ay edent Ever in	U.S. 13	Was Decedent of	21774 Hispanic Origin? (St	pecify Yes or No-		1 States
11. Marital Status 1 X Never Marri	ied 2∏ Marrie	Armed F	orces?	10	If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)	Black, WI	hite, etc.
3 ☐ Widowed		If Yes, G Year or D	ve		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
10	15. Decedent's	s Education		16a. Dec	edent's Usual Occi	upation	ting 16	6b. Kind of Busines	ss/Industry
Elementary/Seco		grade completed) College (1-4or 5+)	life.	DO NOT use retir	e during most of work ed)	Ni /g		
,				I	lomemaker			Own Ho	ome
17. Father's Name	(First, Middle, L	.ast)				18. Mother's Nam	ne (First, Middle, Ma	aiden Surname)	
John Lo	ouro					Jose	ephine Gr	ay	
19a. Informant's Na	ame/Relationshi	ip (Type. Print)		19b. Mai	ling Address (Stree	et and Number or Ru	ral Route Number,	City or Town, State	e, Zip Code)
Melinda_	Dawson	/ Sister							Land 21774
20a. Method of Disp		3 □Removal from	State 20b.	Place of Disp cemetery, cr	oosition (Name of ematory or other pi	ace) Anri	Date 20	Oc. Location - City	or Town, State
	5 Other (Sp				Cremato	ry	2007 F1		Maryland
21. Signature of F	Inoral Service L	icensee	~	1	22. Name and Add	ress of Facility St sumtown P	auffer Fu ike Fred	neral Ho erick, Ma	mes, P.A. aryland 21702
23a. Part1. Enter t	he disease, or o	complications that only one cause on	caused the de	ath. Do not e	nter the mode of dy	ring, such as cardiac	or respiratory erres	st,	Approximate Interval Between
Immediate Cause ((Final		is Syno						Onset and Death
resulting in death)	- 1	u	(or as a conse						
Cognopticity fiet	nditions	_{b.} Pneu	monia						
Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate	Due to	(or as a conse	equence of):					
that initiated events	5	С							
resulting in death) I	Last	Due to	(or as a conse	equence of):					
	3	d				_			
IF FEMALE:						_			
23b. Was deceden			tcome pf preg birth 2 Fe		□Ectopic pregnan	icy		23d. Date of o	
in the past 12 1 ☐ Yes 2	X No		nant at time of		Other (specify)			Month	Day Year
9 Unknown						in the Post of	00- 0144		As the second of least C
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?									
Malnutrition, Absess Left Arm, 1 ☐ Yes 2⊠No 3 ☐ Probably 4 ☐ Unknown									
Non Hea	aling Sk	cin Ulcer	s with	Infect	ion		24a. Was an autopsy performe	ed? I death	autopsy findings available completion of cause of
	to Thr	rive					1□ Yes 2	No 1 □Y	es 2 🔀 No
25. Was case refer examiner?		Hospital:		T EDIC : :		ther	th (Check only one)		
1 ☐ Yes 2 ☒ 27. Manner of Deat		28a. Date	Inpatient 2	ER/Outpation		T I I I I I I I I I I I I I I I I I I I	ome 5 Residen		pecify)
1 ☑ Natural 2 ☐ Accident	n 5 □ Pending investiga	(Moi	of Injury oth, Day Year)		W	uryat ork? ⊒Yes 2 □No	28d. Describe how	mjury occurred	
3 ☐ Suicide 4 ☐ Homicide	6 □ Could no determin	ot be 28e. Plac	e of injury - At	home, farm, s	treet, factory, office	9	28f. Location (Stre	et and Number or	Rural Route Number,

Physician/Medical Examiner Medical Certification: To Be Completed by

Part II. C Ma No Fa 25. Was 1 27. Man 1 🛛 2 🗆 3□ 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

3

31. Date filed (Month, Day, Year) APR

Rajan Shyamsundar,

9801 Gorigia Avenue M.D. 32. Registra Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7

Silver Spring, Maryland 20912

April 14, 2007

D53367

07-02933 Em

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2007 13788

nmaline McKe		State of Maryland / Department of Health and Mental hy For State Certificate of Death	ygierie Reg.	No.				
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death Month D April 16, 200		3. Time of Death 2348 hrs			
Exami		EMMALINE ANNA-MARIA MCKENZIE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	April 16, 200	4c. County of Death				
		Johns Hopkins Hospital Baltimore City		BALTIMO				
Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year I Under 24Hrs 217-67-1318 1 M 2XF 3 Yrs.	┙ `	MM/DD/YYYY) 9. Bir 003				
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
) * .	'n	MD ALLEGANY FROSTBURG			1 Yes 2 X No			
e 5.2	Director	10e. Street and Number 10f. Zip Code 12629 VALE SUMMIT ROAD 21532	UN	. Citizen of What Cou	ES			
ath with the items 23a ist be noti	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? X 13. Was Decedent of Hispanic Origin? (Status of Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer White, etc.	rican Indian, Black,			
fter de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Open,y.	HITE			
hours a natura	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of videring most of working life. DO NOT use retired.)		6b. Kind of Business.	/Industry			
5-0036 led within 72 hours af tygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) N/A		N/A				
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'nysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and			
/ledical ⊏xaminer	6 17	Immediate Cause (Final disease a. Head injuries			Death			
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60, ate be ex hysician e burial -	Physician/Medical	AMENDED #23,27,28a-f, perME, g867 5/16/07 TT IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	ery			
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n of Vi ling Physi After this funeral dir		27. Manner of Death 28a. Date of Injury (Month, Day, Yaar) 28b. Time of Injury 28c. Injury at Work?		ow injury occurred 3.S apassenge:	r in a vehicle/			
Division tal or Attendii rs after death. al Director: A	catic	2 X Accident Investigation 4/10/200/ 11:34 pm 28e Place of Injury - At home, farm, street, factory, office building, etc.	28f Location (S	the head by treet and Number or I	Rural Route Number, City			
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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state of the cause of the ca								
To with To corr	Med	and manner stated. 29b. Signature and title of gertifige. 29c. License number		29d. Date signed (A				
		O.C.M.E.		April 17, 2007				
1		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201					
w	tate	200an regar me i vicination						
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Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	201		Reg.	No. <u>(U U</u>	3. Time of Death
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62 U	Ц		unt Airy nder 1 Year If Under 24Hrs	8 Da	te of Birth/	MM/DD/YYYY) 9. Birt	onlace (State or
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5-0036 led within 73 Hygiene. I other than	ပျ	17. Father's Name (First, Middle, Last)	18.Mother's Nam			iden Surname)	
2121 old be f ental narked	e Be	William McCowan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre	Kayti ess (Street and Number or	Frit Rural Ro	tsch	er City or Town, State	Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be f.led within 72 hours after death with the Maryland Department of Health and ental Tygiene. Important: If item 27 is item 42 item 42	۲	Mrs. Laurie McCowan-Spouse 142 Flee	twood Terrace	, S:	ilver	Spring, M	aryland
Ce, No. 1 and Health	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date		20c. Location - City or	
MOI Pages lent of int: If	, l	1 Burial 2 X Cremation 3 Removal from State Fort Lincoln 4 Donation 5 Other Specify:		/01/	2007	Brentwood	, MD
Baltimore, pernit. Pages 1 ar Department of Hee Important: If ite	الح		nd Address of Facility e Tribute Fur Rockville Pik	nera.	l and	Cremation	Center
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Divisic To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th	cal	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in	the time, date and place, an my opinion, death occurred	d due to	the cause	s) and manner as stated to the place, and due to the	ed. e cause(s)
Nith:	Medical	and manner stated.	29c. License number			29d. Date signed (Mo	
	-	Val 1/2	O.C.M.E.			April 14, 2007	
		30. Name and address of person who completed cause of death (Item 23a)					
			reet, Baltimore, MD 2	21201			
St Regist	ate	31. Date filed (Mc 17 Rv. 227 5 2007 32. Fedistrar's Signature					
Regist	all	- I forther to the same					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 **Physician** 9:52 A APRIL 12 JOANNE MCINTOSH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Days Hours Months 1 □ M 2 🛛 F Iowa 79 Ju1y5,Director 483-20-1551 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Adamstown Maryland Frederick 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number 21710 United States 5923 Lawrence Court Funeral 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Yes 2 No f Yes, Give 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Specify: If Yes, Give Year or Dates: þ 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 4 d 2 should be filed w h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic eve Frances L. Stucker Hall Dee Junkins ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5923 Lawrence Court Adamstown, Maryland 21710 Leslie Hettich / Daughter Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 15 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ZDan Pulmonar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Myo cardya Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence Examiner Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the ass attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes No 9 Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has b rector, page 2 sl autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury (Month, Day Year) Injury 1 Natural 5 Pending investigation M 1 □ Yes 2 □ No 2 Accident Director: 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 2.

OState Registrar

Medical

29a, Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA 801 Caidi 32. Registr s Signature

D43091

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated.

Tou House Ave Brederick My

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 🕕 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Leonard E. McGradv March 4, 2007 9:25 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien @ Bel Air Bel Air Harford If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth Month, Day, Year) 4/17/1916 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1 XM 2 ☐ F 198-10-7256 90 Colorado Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location ? is marked other than "natural", or Itams 23a or 28a-f show traumatic avant, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐XNo Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1909 Emmorton Rd. Apt. 206 21015 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ita 1 ☐ Yes 2000No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ^q Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Home Builder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Milford Garfield McGrady Lula Faye Walthall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Bradford (Guardian) 310 West Bel Air Ave. Aberdeen, MD 21001 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Bel Air Mem. Gdns. 3/8/07 Bel Air, MD 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) **Examiner** 00 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) the 9□ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 1 ☐ Yes 2 ☐ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 tha Hospital or Attanding 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2922 5(37 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Nee Phank Re bel A: MO ZISIY 1) WBYSIL 60 32. Registrar's Signature 200 State Registrar

			1 - For State Registrar	State of Maryla	nd / Dep		lealth and M	lental Hy) () 7	13792
	Physic /Medi		1. Decedent's Name (First, Middle, Las Claire	H•	()'Meara		2. Date of De	_	2007	3. Time of Death 7:30A. M
	Examir Funeral		4a. Facility Name (If not institution, give Manor Care 5. Social Security Number 6. S	ex 7. Age (In yrs	:. last birthday)	Silve	r Spring If Under 24 Hrs. Hours Min.	8. Date of Birt June15	Mon	tgomer	y lace (State or Foreign
64	Director	_	108-20-6432 1 Usual Residence of Decedent 10a. State 10b. County Maryland Prince 0	10c. C	ity, Town or Lo	Months Days	Hours Min.	June15,	(1'92'7		Od. Inside City Limits
	h with the Ma 23a or 28a-f s st be notified	Funeral Director	10e. Street and Number 501 Main Street,			10f. Zip Code 2070	7		10g. Citizen d U ni t e	of What Cour ed Stat	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 【X No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Spe	lace - Americ lack, White, cify: Wh	
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Maryland	hould be file d Mental Hy narked oth natic event	To Be (17. Father's Name (First, Middle, Last) Walter G. Dailey	Tung Print)	10b Maili		18. Mother's Name Mary Mill				Out to
re, Ma	es 1 and 2 si of Health and item 27 Is r other traur		19a. Informant's Name/Relationship (19a Name) Raymond J. O Mears 20a. Method of Disposition			ng Address (Street a W. Caroli Desition (Name of matory or other place Litan Cren			•	Mary 18	
Baltimore,	permit. Page Department of Important: If any injury or once.		1 ☐ Burial 2 ⚠ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen				1				Virginia /land 20705
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		Completed	25. Was case referred to medical				26. Place of Death		rmed? 2 X No	b. Were auto prior to cor death? 1 ☐ Yes	psy findings available npletion of cause of 2 No
on or Vi	ing Phys Afte, this uneral dir	tion: To Be	examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injury Work	r: 4 Nursing Hor		lence 6 □C		<i>(</i>)
Division	ital or tend is after death al Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At h building, etc. (Speci	ify)			City or Tow	n, State)		l Route Number,
	y To the Hospital or "tte within 24 hours after des To the Funeral Directo completely filled in ty th	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam 29b. Signature and the of certifier	vsician: To the best of my kn Ilner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the tim vestigation, in my op 29c. License	oinion, death occurr	ed at the time,	cause(s) and date and place	e, and due to	the cause(s)
	5		30. Name and address of person who co	completed cause of death (Itel	m 23a) (Tvpe.	D5323	35		April	12, 2	
	Sta	ite_	Darryl A. Hill, M 31. Date filed (Month, Day, Year)	I.D. 13635 Bal	timore	Avenue La	aurel, Ma	ryland	20707		
	Registr		APR 16 20	07 Stegistrars Sign	K A	exter)					

DHMH 17 Rev 1/2001

hours after 24

within 24 5 TT nas State

Registrar

31. Date filed (Month, Day, Year) 6 2007

29b. Signature and title of certifier

(Check only

one)



now

30. Name and address of person who completed caused death (Item 23a) (Type, Print)

WELIK, ROBERT A., M.D., 902 SETON DRIVE, SUITE 308, CUMBERLAND, MD 21502

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D31875

29d. Date signed (Month, Day, Year)

APRIL 13, 2007

07-02923 Jeremy Justin Phillips Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 13794

erem	y Jusun Fii	1-	For State	ate of Me		Certific	cate of	Death_					g. No.			3. Time of Death	
ţ.	hysicia	n/ 1.	gistrar Decedent's Name (First, Midd Jeremy	lle,Last)	J	ustin		Phi	 	ps	2. I	Date of Deat Month April 16, 2	Day 007	Year		1515 hrs	
Me€	xamir	ier 4	a. Facility Name (if not instituti	on, give street a	and number)		41	b. City, Tow Swanto		cation of I	Death		- 1	County of Garrett	Death		ļ
	Funeral		15000 Blockof Maryl Social Security Number	6. Sex	7. Age ((In yrs. last b		If Under 1		If Under 2	24Hrs. 8 Min.	3. Date of Bir			Loreidi	nplace (State or Marylan ntry)	d
	Director	- 1	218-06-1104	1 X M 2	F	22	Yrs.									10d. Inside City L	imits
	w any	1	0a. State 10b. County	llegany	1	0c. City, Tow		on umber]	land							1 Yes 2 X	
	vith the Maryland s 23a or 28a-f show a e notified at once.	cto	0e. Street and Number					10f. Zip C	ode				10g. Ci	tizen of Wh	at Cour	itry?	Ì
	he Mai or 28 iffed a	Director	10200 Hill	Lcrest	Drive					1502		y Versen		T14 Page	US - Ameri	A can Indian, Black,	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once.	Funeral	Marital Status Never Married 2 X	Married 12. W	as Decedent Emed Forces? Yes 2	ver in U.S.	If Y	es, specify	Cuban, I	Mexican, I	n? (Spec Puerto Ri	cify Yes or Nican, etc.)	0-		e, etc.	White	
	after d al", or iner m	by Fi		Divorced If Yes, Cor Date		oloted) 16	n Docoder	Yes 2	ccupatio	n (Give k	ind of wo	rk done	16b	. Kind of Bu	isiness/l		
	hours natur Exam	ted b	15. Decedent's Education (Specific Elementary/Secondary (0-1)		est grade comp illege (1-4 or 5		during m	ost of worki	ing life. I	DO NOT U	use retire	d)		C	L a	+: ax	=
	136 hin 72 e. than '	Completed	12	<i>'</i>				Labo	rer		- Namo (I	First, Middle	Maide	Consi		CION	
	5-0036 iled within 7. Hygiene. d other than the Medical	3	17. Father's Name (First, Midd	lle, Last) Josep	h	Phi	llips	. Sr.		Bar	bara	_]	Den	ia	K	imble	
	2121 ould be fit Mental I marked ic event,	o Be	Jerome 19a. Informant's Name/Relation	-			19b. Mailin	a Address	(Street	and Num	ber or Ru	ıral Route N	umber,	City or Tov	vn, State	e, Zip Code)	
	MD 2 d 2 shoul lth and h n 27 is n aumatic	Ĕ	Heidi A. Phi				1212	7 Hea	ther	r Dri	ve,	Hager	sto'	wn, M.	D Z	Town, State	
	e, N 1 and 1 Health item	1	20a. Method of Disposition 1 X Burial 2 Crema	tion 3 Re	moval from Sta		ce of Dispo matory or o										
	Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr	\ \	4 Donation 5 Other	Specify:		Sur	set M	lemori	all	Park of Facility	04/2 v Ada	ms Fa	mil	v Fun	era]	Home,	P.A.
	saltin rmit. epartm nports jury o	l i	21. Signature of Funeral Serv	rice Licensee)	- 1	404 E	ecat	tur S	Stree	et, Cu	mbe	rland	, M	21502	
,		_	23a. Part I. Enter the disease	, or complication	ns that caused	the death. D	o not enter	the mode o	of dying,	such as c	ardiac or	respiratory	arrest,	shock, or h	eart	Approximate Between Ons	set and
1.0	sician ,edica		failure. List only one cal	use on each mile	J.											Death	1
	Examine		or condition resulting in deat	n) Due to	o (or as a cons	equence of):											
		<u></u>	Sequentially list conditions, if any, leading to immediate	b Due to	o (or as a cons	equence of):											
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	ted Insit	Exa	events resulting in death) La	d.	0 (0) 40 4 00.14												
	execu ian and	Medical	UNPENDED	АМ	ENDED									23d. Date	of deliv	erv	
	Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.	ian/Mec	IF FEMALE: 23b. Was decedent pregnant past 12 months?	23 1 1	Live birth Pregnant a	ome of pregnation	2	Fetal death		Ectop	oic pregna	ancy		Month			'ear
	Box 687 death certific the attending p	Physician/	1 Yes 2 No 9	Unknown g	Unknown					si san in E	Port I	23e. D	id toba	cco use co	ntribute	to the cause of de	eath?
	O. E hat the ed by the	v Ph	Part II. Other significant co	nditions con	tributing to dea	ath but not re	sulting in th	ie underlyin	g cause	given in F	-arti.					robably 4 U	
	S, P.	of be											Vas an		b. Were	autopsy findings to completion of c	availabl ause of
	ords w requ	shoul										p	utopsy erform es 2	ed?	death	1?	No
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	tal l ician: s certif	Be G	examiner?	Hosp	ital: 1 Inpa	tient 2	ER/Outpati	ient 3	DOA	Other ₄	Nursi	ing Home 5				ther: Scene	
	Division of Vital Records, and retaining Physician: The law requir is after death. "In Director: After this certificate has been is	filled in by the funeral director,		<u>'</u>	28a. Date of In (Month, Da Apr 16, 200	njury y_Year)	28b. Time			jury at Wo		28d. Desc Driver a	ribe ho uto in	ow injury oc ovolved ir	curred n Collis	sion with pick	up
	OD C ending sath. or: Al	filled in by the fune	1 Natural 5 2 ✓ Accident	Pending Investigation			1455 hrs			Yes 2		28f. Locat	ion (St	reet and Nu	ımber o	r Rural Route Nur	mber, Cit
	ViSi or Att after de Direct	in by	3 Suicide 6	Could not be determined	28e. Place of		ome, tarm, s	street, racto	ry, onice	; parraing,	Oto.	or To 15000 Bl	wn, Sta ock of	ate) Maryland	Highw	ay, Swanton, M	1D
	Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	> -	798. Gettilet 4 Control	ing Physician:	(Specify) -		ige, death o	ccurred at t	he time, my opini	date and ion, death	place, ar	nd due to the d at the time,	cause date a	(s) and mar nd place, a	nner as nd due	stated. to the cause(s)	
	To Twit	completely	one) 2 ✓ Medica 29b. Signature and title of	an	d manner state	ed.	0 1	- 12	9c. Lice	ense numb	рег			29d. Date	signed	(Month, Day, real	r)
	8		30. Name and address of	cerson who com	nció-	of death (Iten	Lete n 23a)	42				. MD.					
	218	3	Patricia Aronica-l		Assistan	t Medical	Examine	er 111	Penn	Street,	Baltimo	ore, MD 2	1207				
		Sta	16 17 17	, Year) 8 2007	32. Regi	strar's Signat	ture	park	,								
	Re	gistr	HIT 3				- 1										

			1- State of Maryland / Department / Department / Department / Department / Department / Departme	artment of Health and Me	ental Hygie	2007	13795
ı	Physic	ian	1. Decedent's Name (First, Middle, Last) Mary Louise Pyle-Ruff	ī	2. Date of Death Month Cebruary	Day 16, 2007	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ebruary	4c. County of Death	7:00 ° M
			408 Barkess Ct.	Aberdeen		Harford	
	Funeral Director		5. Social Security Number 218-34-2333 Usual Residence of Decedent 6. Sex 1 M 20 F 68 7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye OCt • 27 , 1	938 938 938 938 938 938 938 938 938	ce (State or Foreign Land
	Maryland -1 show lied at	tor	10a. State 10b. County 10c. City, Town or Lo			100	d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 23e or 28e st be roti	al Director	10e. Street and Number 402 Wyn Mar Avenue	10f. Zip Code 21001	10g.	Citizen of What Countr	y?
036	72 hours after death with the Maryland "netural", or Items 23e or 28e-1 show office Exercities to a coffice of	by Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R □ Yes 2 X No Specify:	eify Yes or No- lican, etc.)	14. Race - Americar Black, White, et	c.
Maryland 21215-0036	d within 72 ho gjene. ir then "netur it e Modical	Completed	(Specity only highest grade completed) (Give life.	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	g	b. Kind of Business/Indu	
and 5	T1 C2 -	To Be Co	17. Father's Name (First, Middle, Last) Kenneth Crossley	18. Mother's Name ((First, Middle, Main	n home	
	S P E E	ř	19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	ng Address (Street and Number or Rural B6 Pine St., Aberde	Route Number, Ci	ity or Town, State, Zip C Land 21001	
Baltimore,	Pages 1 and 2 nent of Health a int: If item 27 Is iry or other tree			natory or other place)		. Location - City or Town	
Balti	permit. Pages Department of Importent: If i eny injury or once.		21. Signature of Funeral Service Ocensee	Name and Address of Facility Tarring—Cargo Fun Aberdeen, Maryland	eral Hom 21001-		yrana
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	er the mode of dying, such as cardiac or The Pancr ucinoma from	respiratory arrest,	A	pproximate nterval Between onset and Death
(68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Medical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.				
P.O. BOX	that the death certific led by the attending p detached for use as:	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Da	ay Year
	w requires that been signed be should be det	by	Part II. Other significant conditions contributing to death but not resulting in the ur Dialutes Mellitus II Otyper Jen Sim	nderlying cause given in Part I.		co use contribute to the	
Vital Records,		Completed			24a. Was an autopsy performed	? death?	letion of cause of
DIVISION OF VIE	ing Phys	ation: To Be	25. Was case referred to medical examiner? 1				s residen
DIVIS	tel or Attend is after death el Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streeth building, etc. (Specify)	eet, factory, office	f. Location (Street City or Town, St.	and Number or Rural R ate)	oute Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, and estigation, in my opinion, death occurred	d due to the cause at the time, date a	o(s) and manner as state and place, and due to th	od. e cause(s)
)	To t Withi To t	Ž	29b. Signature and title of certifier Levely many M.D.	29c. License number	1	Date signed (Month, Da)	y, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, F LETICIA S. GALVEZ M. D.	Cas S. UNICA	JAVE	· HAURE	FDE
	Sta Registr	te ar	31. Date filed (Month, Day, Year) 7 32. Registrar's Signature 7 2007	Routh o	RALE	IND A	0/8

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	/Medi Examir		4a. Facility Name (If not institution, give				4b. City, 1	Town, or	Location	of Death	Thir		unty of Death	0730	A
	Exami		SunBridge Care				E1	Lkto	n				Cecil		
	Funeral Director		5. Sociat Security Number 6. Se		Age (In yrs. I.	ast birthday) Yrs.	If Under Months	1 Year _ Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day SEPT 14	Year) , 1928	9. Birthp Count Indi	lace (State of try) ana	r Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							0d. tnside Cit	tv Limits
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	th the	Funeral Director	10e. Street and Number		-		10f. Zip	Code			-	0g. Citizen	of What Cour	try?	
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	er deg	nue	11. Marital Status	12. Was Decede Armed Force	es?	S. 13. \	Was Deced	ent of Hi ify Cuba	spanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
36	irs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∏Yes 2 If Yes, Give Year or Date	MNo es:		1 ☐ Yes 2	No 🏋	Specify:			Sp	ec <i>ify:</i> Whi	to	
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and	d be fantal h	Be C	Wilbur Stocks								Gloecke	waldeli Sul	mame)		
ary	2 should be f and Mental I Is marked of eumetic eve	2	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address	(Street a			Il Route Number	r, City or To	own, State, Zip	Code)	
	1 and 2 Health a tem 27 is		Janet Lee/Daugh	ter		28 Ea	ast St	eph	ens D	rive	, Newar	k, DE	19713		
ore,	es 1 a of He of He fitem		20a. Method of Disposition 1 🗆 Burial 2 🖫 Cremation 3 🗆	Damaval from Str	20b. PI	lace of Dispo	sition (Nam	e of her place	9) A	pril	23	20c. Locat	ion - City or To	wn, State	
Ĕ	nit. Pag vartment ortent: I injury o		'4 □ Donation 5 □ Other (Specify		R.A.	. Ferris			2	2007			Cheste		
Baltimore,	permit. Pages Department of H Importent: If ite any injury or of		21. Signature of Funeral Service Licen	see		H :	. Name and	d Addres Home	s of Facilit	, Fune	rals, P eet, El	. A .			
	403 6 0	-	23a. Part1. Enter the disease, or comp	lications that cau	sed the death								MD 219	21 Approximate	9
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of	shys this al dii	2	1 ☐ Yes 2 No 27. Manner of eath	Hospital: 1 ☐ Inp 28a. Date of t	atient 2 E	ER/Outpatien 28b. Time of		_	42		ne 5 Reside			")	
	ng fter	tion	Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	tnjury	M	3c. Injury Work 1 □ Y	a: ? ′es 2 🗆		28d. Describe h	JW INJURY O	ccuried		
=	Dir.	Certification:	3 Suicide 6 Could not be determined	289. Place of	Injury - At hor , etc. (Specify,	me, farm, stre	eet, factory,	office		1	28f. Location (S City or Town		umber or Rura	l Route Numb	ber,
	Hospit 4 hour Funere ely fille	edical C	29a. Certifier Certifying Phyone)	/sician: To the be iner: On the basi and manner	s of examinati	vledge, death ion and/or inv	occurred a restigation,	it the tim	e, date an inion, dea	id place, a	and due to the c ed at the time, d	ause(s) and ate and pla	d manner as st ice, and due to	ated. the cause(s))
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c.	License	number	0	2	9d. Date si	igned (Month)	Day, Year)	
•			· se	MO			1	D0	06	572	20	4	120/	27	
	4		30. Name and address of person who o	ompleted cause of	of death (ttem	23a) (Type, ST SE	Print)	Ste	23B	, 6	lkhoi	M	02	1921.	,
	Sta Registr		31. Date filed (Month, Day, Year) APR 3 0 2007	32. Reg	istrar's Signat	We Sand	2								

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31. Date filed (Month, Day, Year) State 6 Registra

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 32/Registrar's Signature

48 Tarn Terrace Frostburg MD 21532

D0055325

			1 - For State Registrar	State	of Ma	ryland / De C		ent of H ate of I		Mental H	ygiene Reg. Na	Z U U T	13798
	Physici /Medi		1. Decedent's Name <i>(First, Midd</i> Melvin	le, Last) Euge	ne		Rŀ	nodes,	III	2. Date of D Month April	Da	y Year 2007	3. Time of Death 6:50 P M
	Examir		4a. Facility Name (If not institution 1129 Bedford		um <i>ber</i>)		4b. 0	City, Town, or	Location of Dea	<u>^</u>	T	County of Death	h
	Funeral Director		5. Social Security Number 215-82-2447	6. Sex 1 ☑ M 2 ☐ F	7. Age	(In yrs. last birtho	Mont	nder 1 Year hs Days	If Under 24 Hr Hours Mir	8. Date of E (Month, I	Day, Year)	9. Birtl Co	nplace (State or Foreign untry) st Vinginia
	iryland show	_	Usual Residence of Decedent 10a. State 10b. County			10c. City, Town o							10d. Inside City Limits
	ith the Ma or 28a-f	Director	10e. Street and Number	llegany		C	umber 10f.	Zip Code			10g. Ci	tizen of What Co	•
-0030	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f show other treumatic event, the Medical Examinar must be notified at	by Funerai	11.29 Bedfo. 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorces	12. Was Dec Armed F ried 1Yes	orces? 2 X No ive		If Yes,	ecedent of Hi	21502 spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or North Rican, etc.)	10-	USA 14. Race - Ameri Black, White	rican Indian, o, etc.
M-C Z Z	s within 72 hou jiene. r then "nature the Medical E	Completed	15. Deceder (Specify only highe Elementary/Secondary (0·12) 12	nt's Education st grade completed,) (1-4or 5+) (G lif	ive kind oi e. DO NO	Jsual Occupa work done of Tuse retired	furing most of w	orking	16b. K	ind of Business/l	,
yland,	id be filed fental Hyg rked othe ilc event,	To Be C	17. Father's Name (First, Middle, Melvin	-	gene		hodes			ame (First, Midd	le, Maider Fa	Sumame)	rrick
Mary	nd 2 shoulth and N 27 Is mai		19a. Informant's Name/Relations Pamela S. Rhode							Ru <i>ral Route Num</i> Cumber	ber, City	or Town, State, Z	ip Code) 502
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Dallimor	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once.		21. Signature of Frineral Service		Λ	Cumberl	22. Name	and Addres	s of Facility Ac		ily 1		Home, P.A. 1502
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O. BOX 0	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death: within 24 hours after death. To the Functial Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 nant at tir	☐ Fetal death	3□Ectopi 5□ Other	c pregnancy (specify)				23d. Date of deli Month	very Day Year
ָרְ נְיִבְּיִי ביינים	quires that in signed by uld be deta	ρ	Part II. Other significant condition	ons contributing to c	leath but	not resulting in th	e underlyir	ig cause give	n in Part I.		tobacco		the cause of death?
ם מנים	The law re cate has bee page 2 sho	Completed		-						24a. Wa aut per 1 ☐ Yes	opsy formed?	prior to c death?	opsy findings available ompletion of cause of
2	ician: certific ector,	Be	25. Was case referred to medica examiner?	Hospital:				104		eath Check only	оле)		
5	iding Phys th. : After this i funeral di	tlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date	Inpatient of Injury oth, Day	28b. Time	e of	28c. Injury Work	4 Nuising	Home 5 1 Describe		6 □Other (Spec ry occurred	ify)
200	at or Atter s after dea il Director id in by the	Certification;	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	e of Injury ling, etc.	- At home, farm, (Specify)	street, fac		-	28f. Location City or To	(Street an own, State	nd Number or Rui))	ral Route Number,
	he Hospit in 24 hours he Funera pletely fille	Medical C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the Examiner: On the b and man	e best of pasis of e	kamination and/oi	eath occuri	ed at the tim ion, in my op	e, date and place inion, death occ	e, and due to the curred at the time	e cause(s) e, date and	and manner as I place, and due	stated. to the cause(s)
		Σ	29b. Signature and title of certifie		410			29c. License				te signed (Month	
	7		70 Nome and 4			CAN		D50	044			April 16	, 2007
	nds		30. Name and address of person Jose V. L	overia, M	.D.,	912 Se	ton I	Orive,	Cumber	land, MD	21	502	
h	Sta Registr		31. Date filed Month, Day/Year)		Registrar's	Signature	Gaste	2					

			For State Registrar		State	of Maryla	and / Depa <i>Ce</i>		ent of H ate of L		nd M		iene g. No.	007	13799
	Diamaia:		1. Decedent's Nam	e (First, Middle,	Last)							2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medio			Peggy		Jo		Re	exrode	:		April 4			1635 P M
	Examir		4a. Facility Name (If not institution,	give street and n	umber)		4b. Ci	y, Town, or	Location of	Death		4c. Cour	nty of Dea	th
				Braddock						rland					gany
	Funeral Director		5. Social Security N 217-30-2	197	. Sex 1	7. Age (In y	rs. last birthday) Yrs.	Month	ler 1 Year s Days	If Under 24 Hours	4 Hrs. Min,	8. Date of Birth (Month, Day, 02/21/1	Year) 934	9. Bir Co Mar	thplace (State or Foreign ountry) 'Yland
	and w		Usual Residence o 10a. State	10b. County		10c.	City, Town or Lo	ocation							10d. Inside City Limits
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	28e-	ect	10e. Street and Nu	mher					Zip Code			1	Og. Citizen o	of What Co	ountry?
	Se or	₫			ester Ro	oad. Sh	I	, , , ,	•	1502				SA	outiny .
	death ma 23	era	11. Marital Status		12. Was Dec	cedent Ever in	U.S. 13.	Was De	edent of Hi	spanic Origi	in? (Spe	cify Yes or No-			erican Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or itame 23s or 28e-f show other traumatic event, the Mudical Exeminations the multiple as	by Funeral Director		ied 2□ Marrie 4 🖔 Divorced	Armed F d 1 Yes If Yes, G Year or	2 No live No		If Yes, s	ecify Cuba 2∏ No	Specify:	Puerto F	Rican, etc.)	Spec	lack, Whit	White
ğ	2 hou			15. Decedent's	Education		16a. Dece	dent's U	sual Occupa	ition			16b. Kind of	Business	
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	gient gien	Son	12				Lice	ense	d Prac	tical	Nur	se	M	edica	al
pu	a Hy	Be (17. Father's Name	(First, Middle, La	•					18. Mother	's Name	(First, Middle, A	faiden Sum	ame)	
Maryland	Ment Ment arke	ဥ	Labon		Clevel	land	Rexro	ode		Fann	ie		Nola		Grogg
lar	2 sh and lam		19a. Informant's N			,		_				Route Number,			
	l and fealth m 27 her t				n, Jr.		290 D. Place of Dispo			rive,		dericks			22406
Baltimore,	10 to 11 to 14 to 14 to 14 to 16 to 10 to	ĺ		Cremation 3	Removal from		cemetery, crei	matory o	r other place	9)	D	110	20c. Locatio	n - City or	Town, State
ţi	t. Partmer			5 ☐ Other (Spe		Cı	umberlar	nd C	remato	ory 0	4/05	5/2007	Cumbe	rland	d, MD
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			23a. Part 1. Enter 1 shock, or hea	he disease, or o irt failure. List o	omplications that nly one cause on	caused the de each line.	eath. Do not ent	ter the m	ode of dying	, such as ca	ardiac or	respiratory arre	st.		Approximate Interval Between
	Physician		Immediate Cause disease or condition	(Final on	_a Pan	creation	c Cancer	n							Onset and Death Unknown
	/Medical Examiner		resulting in death)	1	Due to	(or as a cons	equence of):								MILLELING WILL
		-	Sequentially list co	nditions.	b	(or as a cons	cocuence of:								
	ted nsit	든	Cause (Disease or	erlying injury	D00 10	(or as a corrs	equence or).								
_6	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death)	S	c Due to	(or as a cons	sequence of):								
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Records, F	8 <u>15</u> 8	Ď	Part II. Other signi	ficant condition	s contributing to	death but not r	resulting in the u	ndertying	cause give	n in Part I.					o the cause of death?
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Re	The lav	E C								····		autops	ned?	prior to death?	completion of cause of
Vital	iclan: Th certificete rector, pag	0	25. Was case refer	red to medical						26 Place C	of Doath	(Check only one	[X]No	1 L Yes	2 No
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Division	er de recto	tt tt	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ed 289. Plac	e of Injury - At	t home, farm, str	reet, fact	ory, office		2	8f. Location (Sti City or Town		nber or Ru	ural Route Number.
ā	tal or	Certification:				zg, 0.0. (apo						ony or roun	, oluto,		
	To the Hospital or Attand within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the laminer: On the land man	e best of my k basis of exami nner stated.	knowledge, deat ination and/or in	h occurre vestigati	ed at the tim on, in my op	e, date and inion, death	place, a occurre	nd due to the ca d at the time, da	use(s) and o	manner as e, and due	s stated. to the cause(s)
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			30. Name and add												
	nds				nith, M.	500	00 Setor	n Dr	ive, (Cumber	land	d, Maryl	and	21502	2
	Sta Registr	_	31. Date filed (Mon		2007	Registrar's Sig	gnature M.	horn	11. 2						

State of Maryland / Department of Health and Mental Hygien@ 13800 1 - For State Registral Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** April 13, 2007 08:54 AM Mary Margaret Reed /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany Midlothian 19907 Old Midlothian Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🗓 F Yrs Director 236-36-1270 81 July 09, 1925 Maryland Usual Residence of Decedent death with the Maryland 10a State 10h Count 10c. City Town or Location item 27 is marked other then "natural", or items 23e or 28a-f show other traumatic event, the Modest Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director Midlothian Allegany Maryland 10e. Street and Number 10f. Zip Code 10g. Cilizen of Whal Country? 19907 Old Midlothian Road U.S.A. Funerai 21543-12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 INO Specify: by 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker 12 homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) : 1 and 2 should be fit Health and Mental H tem 27 is marked of Be Mary Jane Thomas ဨ William E. Drew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is Mary Canfield daughter 948 N. Main Ave. West Virginia 26452-Weston 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If II eny injury or c 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park April 17, 2007 Frostburg Maryland 21. Signature of Funeral Service ! 22. Name and Address of Facility ohu Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final **Physician** acute Cerebral disease or condition resulting in death) 2 weeks /Medical Due to (or as a consequence of): Examiner S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit The law requires that the daath certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4□Pregnant at time of death 5 Other (specify) detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Mûnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one examiner Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Hospital or Attending PI
 24 hours after death.
 Funeral Director: After the letty filled in by the funeral 28b. Time of 28c. Injury all Work? After t 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 00055325 womoch 16,2007 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terrace Frestburg MD 48 Tarin WONSOCK SHIN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 1 2007 Registrar

DHMH 17 Rev 1/2001

07-03000 Michael Lynn Ru		Please Type nthal Sta	e or Print in te of Marylan	d / Depar	rtment o	f Healt	th and		•	_	ible.	201	7 13	80
		Registrar 1. Decedent's Name (First, Middle,	L = 44\	Cen	tificate o	Deati	<u>n</u>		la r	Report Death	g. No.	how the to	3. Time of Death	
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4		5700 Urbana Pike - Ro	om #13			Frede	erick				Fred	lerick		
Funeral		5. Social Security Number 6	. Sex 7.	Age (In yrs. la	st birthday)		er 1 Year		_	Date of Birth	(MM/DD/	YYYY) 9. Bi Forei	rthplace (State or	
Director		218-82-7702	1 X M 2 F		42 Yrs	Month 6.	s Days	Hours	Min.	ecember	02,19		ountry) MD _	
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ours a	d by	15. Decedent's Education (Specif	y only highest grade	completed)	16a. Deceder			ion (Give ki DO NOT u		done	16b. Kind	of Business	/Industry	
6 172 h an "n cal E	lete	Elementary/Secondary (0-12)	College (1-4	or 5+)			iking ine.	DONOTO	ise retired)					
5-0036 iled within 72 Hygiene J other than	ompleted	12			Labor	er	- 1	4 O 8 8 a 4 b a a l a	None /Fir	st, Middle, M		struct	ion	
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2121 auld be fil Mental I marked	To B	19a. Informant's Name/Relationshi			19b. Mailin	g Address	(Stree						e, Zip Code)	
MD d 2 sho lth and n 27 is aumatic		Todd Ruppentha	1/Brother		7510	Mil.	Istoi	ne Roa	ad Ha	ncock.	MD 2	175 0		
E, P I and Healt item		20a. Method of Disposition			Place of Dispo			netery,	Da	ate	20c. Loca	ation - City o	r Town, State	
TOP Pages ent of nt: 1f		1 Burial 2 X Cremation 4 Donation 5 Other Spe			thsbur			orv	04/24	/2007	Smit]	hshure	MD	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Importanten of Health and Mental Hygiene. Important: If titen 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral Service L		, chil				of Facility					Street	-
W FY II	1	Kell	12a	<u> </u>	Gr	ove I	Funei	ral Ho	ome,P	.A.Har	ncock	MD 21	750-0368	
Physician		23a. Part I. Enter the disease, or c failure. List only one cause o		sed the death.	Do not enter	the mode	of dying,	such as car	rdiac or res	spiratory arre	est, shock,	or heart	Approximate In Between Onse	
/Medical		Immediate Cause (Final disease	a Liver ci										Death	
		or condition resulting in death)	Due to (or as a c	onsequence of):									
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68760 rertificate b riding physis	an/	23b. Was decedent pregnant in the past 12 months?	Live oil			etal death	3 [Ectopic	pregnancy		Mo	nth	Day Yes	ar
Box e death c the atten ed for us	Physician/Medical	1 Yes 2 No 9 Unkn	' L.	nt at time of dea	ath 5 C	ther (Spe	cify)		<u>.</u>					
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be execut certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial—tra		Part II. Other significant condition			sulting in the	underlying	g cause g	jiven in Par	t I.	23e. Did to	bacco use	contribute to	o the cause of dea	ith?
P.O. es that the igned by	d b									1 Yes	2 N	o 3 Pro	obably 4 🗸 Unk	nown
rds, requir	Completed								110	24a. Was a			autopsy findings av	
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ital Recician: The		25. Was case referred to medical	1				26.Place	of Death (Check only		2 110	1 🗸	res Z	INC .
Vita ysician his cer direct	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inp	patient 2	ER/Outpatier			Othor	Nursing H		Residence	6 🗸 Oth	er: Scene	
of Vital Records, ing Physician: The law requir After this certificate has been s uneral director, page 2 should I	-	27. Manner of Death	28a. Date of (Month, D	Injury Day, Year)	28b. Time of	Injury	28c. Inju	ry at Work?	28	d. Describe l	now injury	occurred		
ion tendir cath or: A	atio	1 X Natural 5 Pendii 2 Accident Invest	ng	,,,			1 \	Yes 2	No					
Division tal or Attendin rs after death al Director: A	Hice	3 Suicide 6 Could	not be 28e. Place	of Injury - At ho	ome, farm, stre	et, factory	, office to	building, etc	281	f. Location (S	Street and	Number or F	Rural Route Number	er, City
Di spital ours a neral I	Certification:	4 Homicide determ	nined (Specify)							J J				
Division of Vital Records, P.O. Box 68760, vitin 24 hours after death certificate be within 24 hours after death or 70 the Function: After this certificate has been signed by the attending physici completely filled in by the funeral Birector.		[Check only	rsician: To the best of iner:On the basis of											
To the vithing To the comp	Medical	29b. Signature and title of certifier	and manner sta					e number					onth, Day, Year)	1
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State 31. Date filed (Month, Day, Year) istrar APR 3 Registrar DHMH 17 Rev 1/2001 OCME 2006

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

April 20, 2007

Harvey Sheldon Spector

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Registrar			Certifica	ate of l	Death				Reg. No	<u>).</u>			
Physicia	an/	1. Decedent's Name (First, Midd							2	2. Date of De		Year		3. Time of De	
Medical Exami	ner	Harvey Sheld	on Spect	cor						Month April 13,	2007	real		1415 hr	S
		4a. Facility Name (if not institution	on, give street an	d number)		4b	. City, Town, or	Location	of Death		- 1	c. County o			
		31 Juneway Lane					Berlin					Worceste	er		
Funeral		5. Social Security Number	6. Sex	7. Age (In	rs. last birt	hday)	If Under 1 Year		er 24Hrs.	8. Date of I	Birth(MN	//DD/YYYY)		place (State	or
Director		219-38-9303	1 X M 2	E	64	Yrs.	Months Day	s Hours	Min.	03/0	06/1	943	Foreign Cour		D
	ŀ	Usual Residence of Decedent	IZA W. Z	'	07	115.				03/	70 / 1	713		111	
any	ŀ	10a State 10b. County		10c.	City, Town	or Location	n						T	10d Inside (City Limits
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Maryland 28a-f show d at once	희		ester		cean)		10f. Zip Code				10a C	tizen of Wh	et Count	rv2	
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215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once,		31 Juneway					21811				US				
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5-0036 led within 72 hours after Hygiene. other than "natural", in	9	15. Decedent's Education (Spe	ecify only highest	grade complete			S Usual Occupa st of working life				16b.	Kind of Bus	iness/In	dustry	
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thin that that the	ם		3	3	Sa	ıles					Ca	rpet :	Busi	ness	
15-003 Tled withi Hygiene. d other th	Ö	17. Father's Name (First, Middle	e, Last)					18.Mother	's Name (First, Middle	, Maide	n Surname)			
215 e file tal H ked	Be (Daniel Lobe Sp	ector					Min	del	Baski	1				
Z = 2 = 3	P	19a. Informant's Name/Relation)	191	b. Mailing /	Address (Stre	et and Nun	nber or Ru	ıral Route N	umber, (City or Town	, State,	Zıp Code)	
ages I and 2 shount of Health and It. If item 27 is rother traumatic		Sharon P. Spec	tor		3	l Jui	neway,	0cean	Pin	es, MI	21	811			
ore, N s Land of Health If item	H	20a. Method of Disposition		1:	20b. Place of	of Dispositi	on (Name of ce			Date		. Location -	City or T	own, State	
OF Ses 1		1 Burial 2 XX Cremation	n 3 Remov	val from State		ory or othe			04/1	7 /200	, ,	1- F	1	DE	
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Physician	l	23a. Part I. Enter the disease, of failure. List only one cause		fat caused the d	leath. Do no	ot enter the	mode of dying	, such as c	argiac or	respiratory a	arrest, si	nock, or nea	rt	Approximat Between C	Onset and
Examiner		Immediate Cause (Final disease	_{e a.} Intraora	I Gunshot V	J ound									Dea	ath ———
LXammer		or condition resulting in death)	Due to (or	as a conseque	nce of):										
	.	Sequentially list conditions,	b												
	Examiner	if any, leading to immediate cause. Enter Underlying Cause		as a conseque	nce of):										
	ä	(Disease or injury that initiated events resulting in death) Last		as a conseque	nce of):	-							-		_
ted J Insit		events resulting in death) Last	d.	,	,										
1760, freate be executed g physician and the burial - transit	Physician/Medical	UNPENDED	AMEND)FD						-					
O, be e	edi										12	3d. Date of	daliwasi		_
8760, tificate being physicas the buri	ξ	IF FEMALE: 23b. Was decedent pregnant in:	da -	yes, outcome of .ive birth		2 Feta	al death 3	Ectopi	c pregnan	iCV	'	Month	Da	av	Year
Sox 687 leath certiffi e attending for use as t	cial	past 12 months?		regnant at time	of death		er (Specify)		7, -3,	,				•	
Box 68 te death cert the attendir red for use a	ysi	1 Yes 2 No 9 Ur	almaum	Jnknown		Our	SI (Openin)				_1				
D. B the d by the	P.	Part II. Other significant cond	itions contribut	ing to death but	not resultin	g in the un	derlying cause	given in P	art I.	23e. Did	tobacc	o use contri	oute to the	ne cause of	death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	þ									1 🔲 1	es 2	✓ No 3	Proba	ably 4 🗌 l	Jnknown
IS, quire en sig	Completed									24a. Wa	as an	24b. V	/ere aut	opsy findings	available
cords, law requir has been s	ble										topsy formed		rior to co eath?	mpletion of	cause of
Phe la ate h	E									1 🗸 Ye			✓ Yes	2	No
tal Rec cian: The certificate ector, page	ပ	25. Was case referred to medic					26 Plac	e of Death	(Check o	nly one)					
Vital Rec ysician: The l his certificate l director, page	o Be	examiner?	Hospital: 1	Inpatient	2 ER/0	utpatient	3 DOA	Other ₄	Nursing	Home 5	Resid	dence 6 🗸	Other:	Scene	
of ving Phy	.T	27. Manner of Death	28a.	Date of Injury	28b.	Time of Inj	jury 28c. Inj	ury at Wor				njury occurre	ed		
ndin Ith.	io	1 Natural 5 Per		Month, Day, Year)	- 1	JND:	1	Yes 2	No S	Subject st	iot se	"			
Sicological Sicolo	cat		28e	13, 2007 Place of Injury		5 hrs arm, street	, factory, office	building, e	tc.	28f. Location	(Street	and Number	r or Rur	al Route Nur	mber, City
Division of ' pital or Attending Phours after diverser. After terral Director: After titled in by the funeral	Certification:	det	uld not be	ecify) Vehicle					- 1	or Town	, State) Lane,	Berlin, ME)		
Spite hour mera y fill	ပ္ပ	4 Homicide 29a. Certifier 1 Certifying				-16-0-0-16	and not then times a	data and al						d	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Ex	Physician: To the barring of the bar	e best of my kno asis of examina	tion and/or	investigation	on, in my opinio	n, death o	ccurred at	the time, da	ite and p	place, and d	ue to the	cause(s)	
To d withi To d	led		and man	ner stated.	_			se number						th, Day, Year	1
	2	29b. Signature and title of cept) ci		n									, Day, rear	1
		Tohil	hon	-184	Lox	- 45	0.0	.M.E.				oril 14, 20	07		
		30. Name and address of person	n who completed	cause of death	(Item 23a)										
6A 4		Patricia Aronica-Polla		sistant Med		niner	111 Penn S	Street, B	altimore	e, MD 212	201				
4	tate	31. Date filed (Month, Day, Year	Tr 2007 3	2. R gistrar's S	ignature	And	de								
		APR 1	7 2007 I	FT 0-0.48	. 41	A-17.48	The second second								

		•	1 - State Registrar	,	Cei	rtificate of	Death	,	Reg. No.	10U/	138	UJ
۲	Dhyoicic		1. Decedent's Name (First, Middle, Last	!				2. Date of Do Month	eath Day	Year	3. Time of D	
	Physicia /Medic		JOHN		SI	CARKEY		04	12	2007	1515	М
	Examin	er	4a. Facility Name (If not institution, give				r Location of Death			ounty of Death		
			WMHS-BRADDOC 5. Social Security Number 6. Se		yrs. last birthday)	CUMBER:		8. Date of Bi		LEGANY	place (State or I	Foreign
	Funeral Director			M 2□F 7	7 Yrs.	Months Days	Hours Min.	Decembe	ay, Year)	Cour	yland	oroigii
	land ow it		10a. State 10b. County	10	c. City, Town or Lo	ocation				1	I0d. Inside City	
	Mary -f sho fied a	to	Morriand Allocon	.,	Frostburg						1 Yes 2	!□No
	r 28a	Director	Maryland Allegan 10e. Street and Number		Trostouig	10f. Zip Code			10g. Citize	en of What Cour	ntry?	
	th with sit sa court be	al D	144 West	Main Street		21532-			USA			
	ems er mu	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No o Rican, etc.)	0- 12	 Race - Americ Black, White, 		
9	or it	by Fu	1) Never Married 2 Married	1 X Yes 2 □ No If Yes, Give Year or Dates: Ko	read	1 ☐ Yes 2 🕅 No	Specify:		5	Specify:		
Ś	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	g p	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu			dent's Usual Occup	nation		16h Kind	Whi		
2	n 72 n "nat ledica	Completed	(Specify only highest grad	e completed)	ı (Give	kind of work done DO NOT use retire	during most of wor	king		201 00011030/111	duony	
7	withi iene. thar	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Sarra	ant			city r	police depa	rtment	
2	illed I Hyg other	Be C	17. Father's Name (First, Middle, Last)	,	Serge	ant —	18. Mother's Nan	ne (First, Middle	e, Maiden S	urname)	U 112122171	
<u></u>	ald be Alenta rked tic ev	To B	Edgar R. Starkey				Edith E. V	Wegman _				
<u>g</u>	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (T)	pe. Print)	19b. Maili	ng Address (Street			ber, City or	Town, State, Ziţ	Code)	
, E	1 and 2 Health tem 27 i		Elizabeth Stains	sister	20b. Place of Dispo	W. Main St.	F	rostburg		aryland	21532-	
ב כ	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I		20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Loca	ation - City or To	own, State	
	Pages ment of I ant: if its lury or o		4 □ Donation 5 □ Other (Specify,		Cumbe	rland Cremat 2. Name and Addre	OTV A	ril 13, 2007	Cumb	erland Ma	aryland	
Dalmino	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	ee	2	2. Name and Addre	ess of Facility					
	□ □ = # O		John Ta	RUCK	death December	Durst Fune	ral Heme, 57	Frost Ave	Frostl	ourg, MD	21532 Approximate	
			23a. Pag. Enter the disease, or comp	ne cause on each line.	death. Do not en	ter the mode of dyl	ng, such as cardiad	or respiratory	arrest,	0	Interval Betwee	een eath
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	ZYTHO	niA					100 JUC,	100
	/Medical Examiner			Due to (or as a co	onse dence of):		\					
de	7.76	-	Sequentially list conditions,	b. Due to (or as a cu	insequence of	PLASON.	-CICH					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,	J					
,	exec in and ial-tra	Exa	resulting in death) Last	Due to (or as a co	onsequence of):							
00/00	certificate be executed rding physician and ise as the burial-transit	ca		d								
8	rtifica ng ph as th	Medical	IF FEMALE:									
Š	ith ce tendii rr use	5	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐		⊒Ectopic pregnanc	;y		23	3d. Date of deliv Month	ery Day Ye	par
	e dea he at hed fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	e of death 5[Other (specify)				Worth	Day 10	, , ,
Ţ.	w requires that the death cer been signed by the attendir should be detached for use	Physician/	Part N. Other significant conditions co	intributing to death but n	ot resulting in the u	inderlying cause giv	ven in Part I.	23e. Did	tobacco us	se contribute to t	the cause of de	ath?
Š,	ires t signe	Ď	WARRIES Me	11.70						No 3□Pro		
cords	requ	Completed					·	24a. Wa			opsy findings av	vailable
Ď	The law ate has b	Id III						aut	opsy formed?	prior to co death?	impletion of cau	use of
NII GII	n: Th ficate or, pa		25. Was case referred to medical				Of Disease De	1□ Yes	_/	1 □ Yes	2□ No	
=	sicia s certi irecto	o Be	examiner?	Hospital:	2 ☐ ER/Outpatie	nt 3 DOA Ott	26. Place of Dea	***************************************		☐Other (Speci	i64)	
5	g Phy er this	\vdash	27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe			'','	
<u></u>	nding tth. r: Afte e fun	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ear) Injury		Yes 2 No					
VISION	Atte	iffica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc. (\$	- At home, farm, st	reet, factory, office			(Street and own, State)	Number or Rur	al Route Numb	er,
5	tal or rs afte al Dii	Certification:										
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s	edical		sician: To the best of manner: On the basis of ex and manner stated	amination and/or i							
	Fo the within To the somple	Me	29b. Signature and title of certifier	Λ /	7/	29c. Licen:	se number		29d. Date	signed (Month	, Day, Year)	
	3/1UA		KOZ	son Ixlos	4-27	7	721X1=	5	APIZ:	L 13	200	7
(J 1017		30. Name and address of person who o	ompleted cause of death	h (Item 23a) (Type	, Print)	2		0	L 13 Maryla		/
	nas		Robert Wellik	MD 9	02 Seta	on Drive	e Cum	berla	nd 1	Marylo	ind 2	1500
	Ct-	10	31. Date filed (Month, Day, Year)	32. Registrar's	Signature							

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2007 2204 04 08 SPATARO RAYMOND /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY CUMBERLAND WMHS-BRADDOCK CAMPUS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**¼** M 2□ F 220-32-2576 Maryland 70 August 12, 1936 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 □ No Director Frostburg Allegany Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 328 Braddock Street within 72 hours after death with 21532-U.S.A. Apt. 204 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No 'natural", or Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tire manufacturer Finishing Dept. 12 permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tillio "Ted" Spataro Mary Alice Skidmore 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hagerstown 21742-Carla Spataro daughter 13311 J. Hunter Hill Drive Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 12, 2007 Cumberland Maryland Cumberland Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HOUR Physician /Medical Due to (or as a consequence of): Examiner MAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the at 1 □ Yes 2 □ No Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending F after death. I Director; After Natural
Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier 116907 2/1UA

nus

State

Registrar

31. Date filed (Month, Day,

James &

1 APR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 Bishop 32. Registrar's Signature

NAISH ROAD, Cumberland MD 21502

			For	State o	f Marylan				d Mental Hy	/giene			
			1 - State Registrar			Cei	rtificate c	of Death	1000	Reg. No.	2007	3	805
	Physicia	an	Decedent's Name (First, Middle,						2. Date of D Month	Day		3. Time of	Death M
	/Medic		An English Name (If not institution	Charlene		se	Shafer	n, or Location of De	APRIL (007 County of Deat	1800	IVI
	Examin	er	4a. Facility Name (If not institution, MEMORIAL HOSP)		nber)				eatri				
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye		Hrs. 8. Date of B	irth	ALLEGAN 9. Birt	hplace (State o	or Foreign
	Director		215-34-4674	1□M 2∏ F	69	Yrs.	Months Da	ys Hours N	Min. (Month, D 03/11	/1938	Mar	yland	
	p.		Usual Residence of Decedent		1.0								
	arylar show d at	Ē	10a. State 10b. County		10c. Cit	y, Town or Lo		,				10d. Inside Ci	
	18a-f	Director		legany			Cumberl			400"	f148 + 0	11	2010
	a or 2 be n		10e. Street and Number 922 Kent	Avenue			10f. Zip Cod	e 21502		Tug. Citi:	zen of What Co USA	ountry?	
	d within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status		edent Ever in U	S 13 1	Was Decedent		2 (Specify Yes or N	0-	14. Race - Ame	rican Indian.	
	fter d r Iten	Fun	1 □ Never Married 2 Marrie	Armed Fo ed 1 ☐ Yes	rces? 2 [V] No				? (Specify Yes or Nuerto Rican, etc.)		Black, White		
2-0036	al", o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	/e **		1⊡Yes 2∏∏i	No Specify:			Specify:	Nhite	
ည	72 ho natur dical	Completed	15. Decedent's	Education grade completed)		16a. Dece	dent's Usual Oc	cupation ne during most of	working	16b. Kii	nd of Business/	Industry	
7	within 72 ene. than "nai	mpl	Elementary/Secondary (0-12)	College (1	I-4or 5+)		_	ne during most of lired)			**		
2	filed w If Hygie other ti		12 17. Father's Name (<i>First, Middle, L</i>	201)		h	lomemake		Name (First, Middle		Home		
Maryland	ev ev	Be	James	Rauch	ı E	Brant,	Sr.	Doro	,	Bruc		Schade	е
2	2 should and Men is marke aumatic	To	19a. Informant's Name/Relationsh			·			r Rural Route Num			Zip Code)	
_	nd 2 alth a 27 is r tra		Carl C. Shafer	/ husband	[-		umberland		21502		
ē,	es 1 a of Hea	1	20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of matory or other	place)	Date	20c. Lo	cation - City or	Town, State	
altimore,	permit. Pages Department of Important: If It any Injury or o		1 🕅 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		State			1	4/05/2007	Cur	nberlan	d, MD	
all	ppartr porta ny Inja		21. Signature of Fureral Service L	icensee					Adams Fa	•		l Home,	P.A.
מ	9 9 F # 9	1	Kohut C.	adema	/	1	404 Dec	atur Stre	eet, Cumb	erla	nd, MD	21502	
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that only one cause on e	aused the deat ach line.	h. Do not ent	er the mode of	dying, such as car	diac or respiratory	arrest,		Approximat Interval Bet Onset and I	ween
	Physician		immediate Cause (Final disease or condition resulting in death)		Lodyspl		Syndron					2 week	
	/Medical Examiner		, cooling an accum,	Due to	(or as a conseq	uence of):							
	, so the second	er	Sequentially list conditions, if any, leading to immediate	b	or as a conseq	uence of):					-	-	
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. It is a deviced to cause (Disease or injury that initiated events										
o,	an an rial-tr		resulting in death) Last	Due to	(or as a conseq	uence of):							
8/60	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dical	1	d									
٥	ertifica ing ph e as t	Med	IF FEMALE:										
X R R	leath certific attending p I for use as	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	tcome pf pregna pirth 2 Feta	death 3□	Ectopic pregna			2	23d. Date of del Month		Year
	the a	Physiclan/Me	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4⊟Pregr 9□Unkn	nant at time of d own	leath 5L	Other (specify	")				,	
J.	w requires that the de been signed by the should be detached		Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco u	se contribute to	the cause of d	leath?
Hecords ,	uires sign Id be	d by	Acute	Renal Fa	ilure				1 🗆	Yes 2	ÖNo 3⊟Pr	obably 4 □l	Unknown
င္ပ	w rec	Completed							24a. Wa	s an	24b. Were au	utopsy findings	available
	The law cate has b page 2 sl	dmo	***	-					aut	opsy formed? 2 XNo	prior to death?	completion of c	ause of
VItal		Φ	25. Was case referred to medical				·	26. Place of	1 Yes Death (Check only		TLIYES	2□No	
>	nysici is cel direc	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 🛣	Inpatient 2 🗆	ER/Outpatier	nt 3 DOA	Othor:	ng Home 5 ☐ Res		3 □Other (Spe	cify)	
0 0	nding Physician: th. : After this certifica e funeral director,		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o	f 28c. [njury at Vork?	28d. Describe				
<u> </u>	endir eath. or: Al	atic	2 Accident investiga	ation				☐ Yes 2 ☐ No					
UIVISION	br Att ter de Nrect	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and Zoe. Place	of injury - At he ing, etc. (Specif	ome, farm, str (y)	eet, factory, offi	ce	28f. Location City or To	(Street and own, State	d Number or Ri	ural Route Num	nber,
	pital or Attenors after death ours after deatheral Director: filled in by the		29a. Certifier 1 🕅 Certifying	Physician: To the	host of my kno	wledge deat	h occurred at th	a time data and n	Joon and due to th			- state d	
	the Hospital or Attending Physician: in 24 hours after death. the Funeral Director: After this certifical mpletely filled in by the funeral director,	edical	(Check only 2 Medical E	xaminer: On the b	asis of examina ner stated.	ition and/or in	vestigation, in r	ny opinion, death o	occurred at the time	e, date and	and manner as I place, and due	s stated. e to the cause(s	3)
	To the Hospital within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier	\cap	1	Λ	29c. Lic	ense number		29d. Dat	e signed (Mont	h, Day, Year)	
	5		1 Walnuta	211.2 (/1	A TILL	4/	D14	865		APRI	L3 .	2007	
•			30. Name and address of person v	. /							- ,		
	nes		ROBUSTIANO BARRI	-	- FI		L AVENU	E CUMBE	RLAND, MI	2150	02		
	Sta		31. Date filed (Month, Day, Year)	2007	legistrar's Signa	ature	parte						

DHMH 17 Rev 1/2001

Physician /Medical **Examiner** Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" ~~ any injury or other traumatic events. Director Funeral Completed by Be ဥ

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . 2007 APRIL 14, VERA CECILIA TYSON 11:35 A M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BROOKE GROVE FOUNDATION NURSING HOME SANDY SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Days Hours Vear 1 □ M 2 🛪 F 90 270-07-8562 8 1916 New Jersey Nov. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Md. Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20905 United States 1800 Gamewell Road 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗖 No Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Broadcasting Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sedgwick Cecilia Houillion Tyson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1800 Gamewell Road, Silver Spring, Md. Tina Cuff / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4/16/07 Metropolitan Crem. Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home Bar 0. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 LIPIDEMIA 2 No 3 ☐ Probably 4 ☐ Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes No LRAILIT 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes ₽ No 흔 2 ER/Outpatient 3□ DOA After this the funeral 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 🛏 🗂 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D53367 Sincell SHYAMSVANDAL PLATAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annie , SUITE 117, SILLENSPAING MD: GEORG Registrar's Signature 31. Date filed (Month, Day, Year) State 1 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** THOMAS KELITA WILKINSON 10:41 A M APRIL 14 2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1XM 2016 026-16-6954 82 19 1924 Director Connecticut Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Md. Gaithersburg Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 552 Russell Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give WWI 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No WWII Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ifiled within 72 ho I Hygiene. other than "natu 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Industrial Hygienist Medical Science 12 should be filed w h and Mental Hygiel Is marked other th 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic ew Eva Kelita Wilkinson Stevenson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice G. Wilkinson / Wife 552 Russell Avenue, Gaithersburg, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Metropolitan Crem. 4/16/07 Alexandria, Va. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility,
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee 20882 Box 5038, Laytonsville, Md. P. O. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** GASTROINTESTINAL BLEED /Medical Due to (or as a consequence of) Examiner CIRRHOSIS Sequentially list conditions, if any leading to it is cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9□Unknown 9 ☐ Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 X Natural 5 Pending investigation Hospital or Attendin 24 hours after death. Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 2 APRIL 14, 2007 41 use of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

WILKINSON

APR 16 2007 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

istrar's Signature

8600 OLD GEORGETOWN ROAD, BETHESDA, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 2007 4a. Facility Name (If not institution, 4c. County of Death give street and number) 4b. City, Town, or Location of Death Wicomico a If Under Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 1 □ M 2 T F 10/12/1917 89 Maryland 215-26-5473 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Girdletree Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 5748 Onley Road 21829 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 至 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Sales 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norman Cleveland Swift Georgia Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Mill Pond Ln., Unit 406, Salisbury, MD 21804 Peggy Burgess (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bethany Methodist Cemetery 4/24/2007 | Pocomoke City, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of FunerahService Licensee HOLLOWAY Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pandio Due to (or as a consequence of): disease or condition resulting in death)

Physician /Medical Éxaminer

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

attending physician for use as the buria

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

within 24 hours fer death.

To the Funeral Director After this completely filled in by the funeral is

ertification: To Be Completed by Physician/Medical Examin
Be Completed by Phy
Be Completed
a 2

Medical

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed gauss of death (Item 23a) (Type, Print)

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes No 1 Yes No 1 Yes No
25. Was case referred to medical examiner?		ath (Check only one)
1 ☐ Yes 27 No	Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	fome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	ysician: To the best of my knowledge, death occurred at the time, date and place niner: On the basis of examination and/or investigation, in my opinion, death occurred manner stated.	

29c. License number

026278

bx1733 Salish

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

BA3

2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Helen Virginia Walters 3 DY /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cumberland Lions Center for Rehab & Ext. Care 8. Date of Birth (Month, Day, Year) 06/29/1918 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days Hours 1 □ M 2 🔀 F 88 214-05-6330 Director Usual Residence of Decedent 10c. City, Town or Location death with the Maryland 10a. State 10b. County 28a-f show ns 23a or 28a-f shov must be notified at Cumberland MD Allegany **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21502 54 Marion Street permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a and hinjury or other traumatic event, the Medical Examiner must by once. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Watters, He Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed by 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Frederick Merten Alderton ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13610 Scofield Road, Flintstone, MD Frederick Streett / nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Hillcrest Mem. Park 104/17/2007 Cumberland, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Buneral Service Licensee 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cell Carcinoma Metast Kemal Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Display to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably Completed 24a. Was an has e 2 page perform 1∐ Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Certification: After Injury 1 Natural 5 Pending investigation

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

24b. Were autopsy findings available prior to completion of cause of death? 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

23d. Date of delivery

Dav

4 Unknown

Month

3. Time of Death

9. Birthplace (State or Foreign

White

Crabtree

21502

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 N Yes 2 No

700G

Allegany

Maryland

14. Race - American Indian.

Black, White, etc.

Retail

Specify

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

M.D.

and manner stated.

29d. Date signed (Month, Day, Year)

MUS State

Medical

Ou 31. Date filed (Month, Day, 1 20

APR

29b. Signature and title of certifles

6 Could not be

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

32. Régistrar's Signature

625

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

within 24 hours after death

To the Funeral Director:
completely filled in by the

12

29c. License number

Cumberland,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 12, Day 2007 April **Physician** 8:25 P M Pamela Jeanne Nachman Yim /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Mar . 27, 1935 England 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛈 F Mar. 549-48-7881 72 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 13809 Rippling Brook Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Jewelry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack Hart (unk) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Nachman/daughter 625 Chestnut Ave. Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 04/16/07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** aLewy Body Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: ${}_{4\square \, \text{Nursing Home}}$ 5 $\square \, \text{Residence}$ eV Other (Specify) hospice 1 ☐ Yes 2 X No မှ 2 ☐ ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 1 X Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

100 (0)

31. Date filed (Month, Day, Year) State Registrar

2007 **APR 16**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Cynthia M. Williams, D.O. 6001 Muncaster Mill Rd. Rockville, MD 20855

Jullomo DO

H0058032

Examiner Box 68760. Ö ۵ Records, or Vital Division

certificate be executed physician and the burial-tran the as attending I use signed b peen has page certificate this funeral After t or Attending death Director: / hours after within 24 hours at To the Funeral D Hospital Medical

Funeral

Director

show

28a-f

items 23a

l be filed within 72 hours after ontal Hygiene. ed other than "natural", or iter

and Mental

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ew

Physician

/Medical

Baltimore, Maryland 21215-0036

death with ö

Examiner must be notified

the Medical

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5

29a. Certifier

(Check only one)

Registrar

31. Date filed (Month, Day, Year)

Courbano

6

29b. Signature and title of certifier



and manner stated.

29c. License number MO

D14864

29d. Date signed (Month, Day, Year)

APRIL 10TH, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 500 MEMORIAL AVENUE, SUITE 201, CUMBERLAND, MD 21502 BARRERA, ROBUSTIANO J.,

🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 230 **Physician** 25 200 NUSZEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BATTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours Days 1 M 2 F July18,1953 Maryland 53 218-58-8260 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 23a or 28a-f shows ust be notified at 1 XYes 2 No Baltimore Md. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21224 704 South Clinton Street r than "natural", or items 23a the Medical Examiner must Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2√2 No White altimore, Maryland 21215-0036 3 ☐ Widowed 4 ➡ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of health and Mental Hygiene. Important: If item 27 is marked other than "naturally injury or other traumatic event". Elementary/Secondary (0-12) College (1-4or 5+) Own Home <u>Home Maker</u> 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Hanks Joseph Bartkowiak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7935 Wooded Glen Court Pasadena, Md. 21122 Clinton Anuszewski -son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 4-30-2007Baltimore, Maryland 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service License 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final MYULOGENOU **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician sthe burial Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2 De No 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 No Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate 1∐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 252 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 1 ☐ Yes 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital To the Hosp within 24 hor To the Fune completely fi

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0 1

ERONICA

22 S. GREENE ST. LINARES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

BATTIMONE, MO

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie [] For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** April 28. 2007 Mary Belle Breiter 10:20 am[™] /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Edenwald Towson Baltimore Hours Min. 8. Date of Birth (Month, Day, Year)
Sept. 13,1912 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months 1 ☐ M 2 ☐ F 94 218-18-4455 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shor must be notified at 1 ☐ Yes 2√ No Completed by Funeral Director Maryland Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 800 Southerly Road 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. T Yes 2 No 1 Never Married 2 Married the Medical Examin Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) IndustrialInstrumentation Secretarv 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H Raymond William Bay, Sr. Martha Jane Anderson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health 2137 Fountain Hill Drive Kathleen Dickman / Daughter Timonium, Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State = 5 Department of Important: If any injury or Bethel Pres. Ch. Cem. 5/1/2007 1 4 ☐ Donation 5 ☐ Other (Specify) White Hall, Md. 21. Signature Funeral Struce Lice ee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral HOme, Inc. Towson, Md. 21204 23a. Part1. Enter the deease, or conditications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician . /Medical Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Physiclan/Medical Examiner burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Natural 2 Accident 5 Pending investigation 1 Tes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 T Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Pay, Year) 29c. License number 29b. Signature and title of certifier s of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certification Cer	ificate of L	Death	morna	Re	g. No.	01 1001.	
Physicia	n/	Decedent's Name (First, Middle,Last)				2. Date of Deat Month	h Dav Year	3. Time of Death	
ledical Examir		Katherine Badong				April 25, 2	007	1500 hrs	
		Facility Name (if not institution, give street and number) 110 West Main Street Apartment B	1	. City, Town, or Lo Frostburg	ocation of L	eatn	4c. County of D Allegany	reatn	
Funeral		Social Security Number	J. Birthplace (State or						
Director	- 1		52 Yrs.	Months Days	Hours	1.0	3, 1954 F	oreign North Country) Carolina	
	L	Usual Residence of Decedent	72 1,0.				,		
any		10a. State 10b. County 10c. City, T	own or Location	1				10d. Inside City Limits	
Maryland 28a-f show	5	Maryland Allegany	Frost	ourg				1 Yes 2 X No	
Maryl 28a-1	<u>ق</u> ا	10e. Street and Number		10f. Zip Code 21532		11	og. Citizen of What		
with the Maryland ms 23a or 28a-f sho		110 West Main Street Apartment I	USA						
ath wi	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?		s, specify Cuban, N		? (Specify Yes or No- uerto Rican, etc.)	White, e	American Indian, Black, etc.	
ter de:		1 Yes 2 No 3 XWidowed 4 Divorced If Yes, Give Year	1 1	res 2 X No	specify:		Specify:	White	
hours af "natural Examin	d b	or Dates:	16a. Decedent's	Usual Occupation	n (Give kin		16b. Kind of Busin	ess/Industry	
6 72 hc cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		t of working life. D		e reurea)	C1	C	
withir iene ner th	틹	/	DUSII	nesswomar		Name (First, Middle, I		ng Service	
filed filed of the	Be C	17. Father's Name (First, Middle, Last) Unk •		10		tricia Gur			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street a		er or Rural Route Nun		State, Zip Code)	
MD id 2 sho ilth and m 27 is aumati	$\lceil \rceil$	Kathy Baka, Daughter	6988 Mea	dow Point	Terrac	e New Market	t, Maryland	21774	
re, l f Heal f Heal f item			ace of Dispositi ematory or othe	on (Name of ceme er place)	etery,	Date	20c. Location - C	ity or Town, State	
MO Pages nent of		Meta	co Crema	atory Ind	c. (04/28/07	Baltimo	re, Maryland	
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If Item 27 is marked other than injury or other traumatic event, the Medical	-	21. Signature of Funeral Service Licensee	22. Na	me and Address of CEMATION	of Facility SOC1	ety Of Mar	yland, I	nc.	
	-1	21. Signature of Funeral Service Licensee Thomas Gregor Jomas June 23a. Part I. Enter the disease, or complications that caused the death. I	Do not enter the	99 Freder	rick	Road Balti	more, Mar	ryland 21228 Approximate Interval	
Physician 'Medical		failure. List only one cause on each line.						Between Onset and Death	
taminer		Immediate Cause (Final disease or condition resulting in death) a. Alcohol and mixed Due to (or as a consequence of)		rpnine,quei	tiapine	e) intoxicat	ion		
		Sequentially list conditions, b							
	Examiner	if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause	•						
±	xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)							
760, icate be executed physician and the burial - transit		d. X AMENDED #23a, per\	Æ. e868.	6/11/07 T.	Т				
'60, ate be e? ohysiciar ne burial	Medical	#23a,PII,27,28a-f.	perME_s	2867 <u>,</u> 5/7/0	07 TT		23d. Date of de	divory	
876 tificat ng ph		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregn 1 Live birth		al death 3	Ectopic p	regnancy	Month Month	Day Year	
Box 68's death certifithe attending	sicie	past 12 months? 4 □ Pregnant at time of death 5 □ Other (Specify)							
P.O. Bc that the de- ned by the a detached fe	Physician	Part II. Other significant conditions contributing to death but not re-	sulting in the un	derlying cause giv	ven in Part	I. 23e. Did to	obacco use contribu	ute to the cause of death?	
P.O es that t			_	,		,	s 2 No 3	Probably 4 V Unknown	
cords, P. law requires the has been signed to a should be de-	Completed by					24a. Was		ere autopsy findings available	
e law	dm						rmed? dea	or to completion of cause of ath? Yes 2 No	
Vital Reco ysician: The law his certificate has director, page 2 s		25. Was case referred to medical		26.Place o	of Death (C	1 Yes	2 NO 1	y res 2 No	
Vita ysicial his cer	e Be	examiner?	ER/Outpatient	3 DOA	Other 1	Nursing Home 5	Residence 6	Other: Scene	
Division of Vital Records, tal or Attending Physicians: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the fineral director.	\vdash	27. Manner of Death 28a. Date of Injury	28b. Time of In		y at Work?		how injury occurred	1	
ion Itendi Jeath.	atio	2 Accident investigation	Fnd 3:00	hin	es 2X N	unknow			
ivis lor A after of Direct	Certification:	3 Suicide 6 Could not be determined (Specify) found in			uilding, etc.	or Town.	State)	or Rural Route Number, City	
Division Hospital or Attence 24 hours after death Funeral Director: stely filled in by the		4 Homicide (Spanny) Totald III			to and place		nin St. From		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial. Transi	Medical	(Check only one) 2 Medical Examiner: On the best of my knowledg	e, death occurr d/or investigation	on, in my opinion,	death occu	e, and due to the cau irred at the time, date	and place, and due	e to the cause(s)	
To To cor	Me	29b. Signature and title of certifier		29c. License	number		29d. Date signed	(Month, Day, Year)	
		(and Hallan	\sim	O.C.M	Л.E.		April 26, 200)7	
		30. Name and address of person who completed cause of death (Item							
				treet, Baltimo	ore, MD 2	21201 			
St Regist	ate trar	MAV 8 7 2087 - 4	1 has	de la					
DHMH 17 Rev 1/2	**		ORIGINAL	_					
	1		~VIII7/L	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 28,200 Tea **Physician** 7120 A M APRII Catherine Martha Butler /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE SAINT AGNES HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct. 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 7 F 68 1938 Oct. Maryland Director 219-26-5473 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Baltimore Lansdowne the 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. p or ns 23a (must b 21227 104 Fourth Ave. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 ö Specify. Specify: White 2 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) than the M Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the 1 once. 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Mayorshi Elizabeth Mayorshi (maiden unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Butler, son 1710 A Wilson Ave. Baltimore, MD. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition West Arundel Crematory 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04-30-07 Odenton, MD 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature of Puneral Service Licenson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, interval Between Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HOURS **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2XNo 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate 1□ Yes 2XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After t 1 Natural 2 Accident (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760. CATHERINE BUTLER

al or Attending Physician: after death.

To the Hospital within 24 hours at To the Funeral I Medical State

Registrar

29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number P20656

Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) APRIL 28, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KONSTANTIN ZUBELEVITSKIY 4005 CATON AVE., BALTIMORE, MD 21229

31. Date filed (Month, Day, Year) 2007

3 ☐ Suicide

29a. Certifiei

4 Homicide



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Director:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician Brown \mathbf{P}^{M} Dorothy Ε. 3:35 27, 2007 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Eldercare -Heritage Center Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛣 F June 16,1922 217-16-8973 Ohio Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 ☐ No Director Maryland | Baltimore Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or ? must be r death with 7300 Kirtley Road 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 'natural", or items a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itel iny or other traumatic event, the Medical Examiner. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Haussners Restaurant Cashier 8 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Martin Lagon Lagon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy Dimick Daughter 7300 Kirtley Road, Dundalk, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If itel any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 1, 2007 Dundalk, MD. Sacred Heart of Jesus 4☐Donation 5☐Other (Specify) Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Par 1. Enter the disease, or complications that caush ck, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Couse (Final disease or condition resulting in death) FIBRILLATION **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ inknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending within 24 hours after upon...

To the Funeral Director: After the Funeral Director of the funeral of the funera 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: the

DHMH 17 Rev 1/2001

State

(Check only one)

29b. Signature and title of certifier

and manner stated

Registrar's Signature

Mame and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 10:35 AM April 2007 Bruno E. Brotto 26 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Stella Maris Hospice Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1**X** M 2 □ F Dec. 10, 1920 Italy 86 Director 216-28-6613 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Catonsville Director Maryland Baltimore death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21228 2108 Chantilla Road Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. iled within 72 hours after ty Yes 2 No If Yes, Give Year or Dates: 1 Never Married 3 Married 1 ☐ Yes 2▼ No 21215-0036 Specify Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hair Barber 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Baltimore, Maryland Be t and 2 should be f Health and Mental Carla Parisotto Cirillo Brotto permit. Pages 1 and 2 should Department of Health and Men 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2108 Chantilla Road, Catonsville, Maryland 21228 Wife Gabriella Brotto Important: If item 27 any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 04/30/2007 Baltimore, Maryland Lorraine Park Cem. 22. Name and Address of Facility Sterling Ashton Schwab Witzk Funeral Home of Catonsville, Inc 1630 Edmondson Avenue, Catonsville, MD 21228 Ashton Schwah Witzke iseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. Approximate Interval Between Onset and Death 28a Part1. Enter th shock, or hear Immediate Cause Final disease or condit in resulting in death Physician RECTAL CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed use as the burial-transi and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. a I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signated to should to Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 1□ Yes 2X No or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ▼ No 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated.

the

BRUNO BROTTO

10:35

2007

State Registrar

TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

1

MAY 0

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

	Registrar Certificate of Death	Reg. No.	
Physician /Medical	1. Decedent's Name (First, Middle, Last) Barbara R Boushell-White	2. Date of Death Month Day Year, 28 200	3. Time of Death 7 12:35A M
Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location o Buttimore Washington Medical Center Chen Burni	e mo Anne	Arundel
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 19-38-7152 70 Yrs. Wonths Days Hours	24 Hrs. 8. Date of Birth (Month, Day, Year) 2-9-1937 9. Bir	thplace (State or Foreign ountry) MD
Maryland -f show first at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Baltimore Baltimore		10d. Inside City Limits 1 ☐ Yes 2 No
tter death with the Maryland frems 23a or 28a-f show dharmoust ba notified at Funeral Director	10e. Street and Number 10f. Zip Code 401 Gun Road 21227	10g. Citizen of What C	ountry?
or its	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, Specify Cuban, Mexican 1 Yes 2 No Specify:		
ygiene. ner then "natural", or Ite it, the Medical Examina Completed by Ful	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired) Accounting	of working 16b. Kind of Business Hotel	Vindustry
arked other atic event.	17. Father's Name (First, Middle, Last) John Mitchell 18. Mothe	r's Name (First, Middle, Maiden Sumame) Helen Fairall	
alth and h	Mrs. Lynda Dawson/daughter 1301 Boxgrove Crt.	or or Rural Route Number, City or Town, State, Pasadena, MD 21122	Zip Code)
ment or me tant: If iten jury or oth	20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Cremation 1 Chesapeake Cremation 1 Che		lle, MD
Uepartment of Important: If eny injury or once.	M01364 1 Second Ave SW	Singleton Funeral Ho Clen Burnie MD 21061	
nysician Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	and disease	Approximate Interval Between Onset and Death
- T	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
	resulting in death) Last Due to (or as a consequence of): d		
the ette	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	23d. Date of de Month	blivery Day Year
8 g	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	o the cause of death? robably 4 ⊟Unknown
certificate has been s rector, page 2 should		performed? death? 1 Yes 2 No 1 Ye	utopsy findings available completion of cause of s 2 No
this certifical director	examiner? 1 Yes 2 No Hospital: \(\) Inpatient 2 \(\) ER/Outpatient 3 \(\) DOA \(\) Dther: 4 \(\) Nu	of Death (Check only one) rsing Home 5 Residence 6 Other (Sp. 28d. Describe how injury occurred	ecify)
To the Funce Director: Alter this certificate has completely tilled in by the funeral director, page 2 Medical Certification: To Be Comp	27. Manner of Death State of Injury 28b. Time of Injury 28c. Injury at Work?		Bural Route Number,
To the Traspital or Attending You for the Transpiration of the Transpira	29a. Certifier (Check only 29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, deal	d place, and due to the cause(s) and manner a	
To the Hospi within 24 hou To the Funer completely till	29b. Signature and title of certifier 1 one one) 29c. License number	29d. Date signed (Mor	
x []	1 hanta mal. D43977	APRIL 2	8 2007

State Registrar 31. Date iled (Month, Day, Year) 20 32. Registrar's Signature

07-03204 Elizabeth Beason

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Carron	LJ.	The said	- i	- 1	1	10	- 1	

abeth Beason		1- Fo	State of Maryland / Department of Health and Mental Hygic or State	Reg. No		
* huninis		Dogi	2 Da	ate of Death onth Day	Year	3. Time of Death 2315 hrs
* ¹ysicia ≟xami	****	,, ,	App. Boason	onth Day oril 26, 2007	c. County of Deat	
			Facility Name (if not institution, give street and number)		n/	
			1207 Hull Street	Date of Birth (MI		rthplace (State or
Funeral			Social Security Number 6. Sex 7. Age (III yrs. last billiday)	ug. 8,	1949 Forei	gn MO ountry)
Director			94-34-9132 1_M 2=FF			
- Ai			ual Residence of Decedent a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
_ 6 W BI			Maryland n/a Baltimore			
ryland a-f sh	cto		e Street and Number		citizen of What Co ted Stat	
ith the Maryland 23a or 28a-f show any notified at once.	Director	1	207 Hull Street 21230			erican Indian, Black,
with t is 23a	ā	11.	. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rica	y Yes or No- an, etc.)	White, etc.	STOOT WARE
death or item	Funeral		Never Married 2 Married 1 Yes 2 X No		Specify: Whi	ite
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36 nin 72 E. than '	1 8		12 years I year bales	No. 10 Mail		
ed with	Completed	17	7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Dine Coll	um	ien Sumanic)	
21215-0036 nuld be filed within 7 Mental Hygiene. marked other than	a	1	Glenn Martin 19b. Mailing Address (Street and Number or Rura	al Route Numbe	r, City or Town, St	ate, Zip Code)
D 21215-003 should be filed within and Mental Hygiene. it is marked other the matic event, the Med	٦	19	9a. Informant's Name/Relationship (Type, Print) Angele Shaffer (daughter) 19b. Mailing Address (Street and Number of Rule) 1614 S. Hanover St. Bal	timore,	MD 2123	·
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland calth and Mental Hygiera (send and Mental Hygiera), or items 23a or 28a-f sho tream 71 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once		20	Oa Method of Disposition (Name of certifier)		0c. Location - City	l l
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Intent 1 itien 27 is marked other than "natural", non-retreatment event, the Medical Examiner monther traumatic event, the Medical Examiner.		1	X Burial 2 Cremation 3 Removal from State St. Peter Cemetery 5-1-2		t. Charl	
timent rtment		2	22. Name and Address of Facility	neral Ho	me, P.A.	
Baltimore, permit. Pages I and Department of Heal Important: It item in intervent or other transitions or other transitions.			TO THE WAY HE COLUMN THE TOOL FOR TWO DATE		110 414	Approximate Interval
'sicia	_	2	3a. Part I. Entire disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.	espiratory direct	, 6110011, 41 112	Between Onset and Death
Medica, Examine			a Intra-oral Gunshot Wound			
LXamme		٥	or condition resulting in death) Due to (or as a consequence of):			
	1	a s	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
			cause. Enter Underlying Cause (Disease or injury that initiated C. Due to (or as a consequence of):			
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6876(certificate	e as th	2 au	by Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)			
Box 68760, e death certificate be the attending physic	for us	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	Too Billion	was contribut	te to the cause of death?
O. Be trithe de by the	ched		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			Probably 4 Unknown
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tal Rectinn: The		Bec	25. Was case referred to medical examiner? Hospital: The solution of the solut	g Home 5	Residence 6	Other: Scene
Division of Vital Records, rat or Attending Physician: The law require the free deal in the law frequire and the recent After this certificate has been similar to the string or the str	direc	0	1 Ves 2 No		ow injury occurred	
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ivis lor A after Dire	d in b	Certification:	3 V Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse		tate) et, Baltimore, M	
Division of Vital Records, P.O. Box Hospital or Attending Physician: The law requires that the death 24 hours after death Francal Director: After this certificate has been signed by the atte	ly fille		4 Homicide	due to the caus	e(s) and manner a	s stated.
Division To the Hospital or Attendii within 24 hours after death To the Funeral Director:	completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, seast essential and manner stated.	it the time, date		d (Month, Day, Year)
€	CO	Mec	29b. Signature and title of certifier		April 27, 20	· ·
	-		O.C.M.E.		, p	-
5	1		30. Name and address of person who completed cause of death (Item 23a) Super Hoggs MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
J			Susaii riogari vib. Assistant modes			
		tate				
Re	egis	trar	MAI VI COUL JOHNSON			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death. Day Year 6:33 A M 28, April 2007 Otho Lee Boothe 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Days Hours 1**X** M 2 □ F Jan. 12, 1925 Virginia 82 218-16-2419 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Harford Darlington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21034 3331 Cedar Church Road USA 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Construction 5 Construction Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jettie Odell Boothe William Rueben Boothe 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret C. Boothe / Wife 3331 Cedar Church Road, Darlington, Maryland 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Bel Air Memorial Grdn 5-2-07 Bel Air, Maryland 21. Signature of Fundral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 for a first studed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or see on elocyting. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only on complications. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Houn onsequence of) evoso if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 20 years Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2€ No 24a, Was an autopsy 1□ Yes 🔊 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 200No 21 ER/Outpatient 3 □ DOA 1 Inpatient 27. Manner of Death

m0000000 **Examiner** burial-transit and Box 68760, signed by the attending physician be detached for use as the burial P.0. Division or Vital Records, certificate has been si rector, page 2 should this

funeral director, after death Director: filled in by Hospital or 124 hours a' within 2.

Physician/Medical

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Completed

Be

Certification: To

Medical

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ortant: If Item 27 Is marked other than "natural", or Items 23a or Injury or other traumatic event, the Medical Examiner must be r

and Mental Hygiene. Is marked other than

permit. Pages 1 and 2
Department of Health au
Important: If Item 27 Is any Injury or any

Physician

/Medical

Baltimore, Maryland 21215-0036

L0/82/h0

Director

Funeral

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Completed

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State Registrar Part/It: Other significant conditions contributing to death but not/esulting in the underlying eause given in Part I.

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d Date signed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

FURE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

5 Pending investigation

6 ☐ Could not be

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 11:11 a Cynthia Brown Apr 26, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner **Baltimore Baltimore** 3610 Forest Hill Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 M 2 □ F No. Carolina Director Jan 16, 1950 215-52-0182 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 D¥Yes 2 □ No Director **Baltimore** N/A Marvland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 21207 U.S.A 3610 Forest Hill Rd death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or items the Medical Examiner mu Black, White, etc. 1 □Never Married 2 □ Married 1 □ Yes 2 □ No Baltimore, Maryland 21215-0036 Specify: <u>م</u> Black 3 ☐ Widowed 4 ☐ Divorced ear or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4or 5+) **Baltimore City School System** Teacher 12 marked other If item 27 is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ' Mae Smith Eddie Brown ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 5123 Pembridge Avenue Baltimore, Maryland 21215 Edward Brown Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Purial 2 ☐ Cremation 3 ☐ Removal from State 05/01/07 Baltimore, Maryland 5 Other (Specify) 4 Dopation Lorraine Park Cemetery & of Funer S rvice Livense 22. Name and Address of Facility 21. Signatur Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 de of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode Approximate Interval Betw Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of). r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial Physician/Medical as attending properties as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 21110 certificate 1□ Yes 2 110 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2[] NO 2 1 🔲 Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending Physician: Director: Funeral D hours 24 within 2.

> State Registrar

Medical

31. Date filed (Month, Day, Year) 0

29b. Signature and title of certifier

30. Name and address of person who

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

6 ☐ Could not be

determined

32 Registrar's Signature

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

cause of death (Item 23a) (Type, Print)

Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** BETHELDA MAE BOWERS 11:30A M 26, 2007 APRIL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** WESTMINSTER CARROLL 1225 WOODS RD. If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2127 F 220-18-1392 81 Director 2/16/1926 PENNSYLVANIA Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Ex miner must be notified at 1 ☐ Yes 2 X No Director CARROLL WESTMINSTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21158 1225 WOODS RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No þ Specify: 3 ☐ Widowed 4 🎖 Divorced WHITE Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL SECRETARY DOCTOR 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLARENCE HOOVER MADELINE MASONHEIMER ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 WOODS RD., KEVIN SHIPLEY 1225 WESTMINSTER, MD 21158 - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/2007 4□Donation 550Other (Specify) ENTOMBMENT EVERGREEN MEM. GARDENS FINKSBURG, MD eral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. MD 21157 WESTMINSTER, 254 E. MAIN ST., Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on expline. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or it jury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 Ø No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 2/2 No 1 Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

P.O. Box 68760, Division or Vital Records, certificate Hospital or Attending Physician: director, nours after death.

neral Director: After this y filled in by the funeral di this

3altimore, Maryland 21215-0036

Medical Certification: To

1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

5 Pending investigation

6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License numbe

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kup 31. Date filed (Month, Day, Year)

Stoner 32. Registrar's Signature

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State

within 24 hours a

To the

completely

		1- For Amend #20b, per Registrar	State of Maryland FH, g867, 5/1/07 T	d / Depar Certi	tment of F ificate of	dealth and <i>Death</i>	d Mental Hy	ygiene Reg. No	2007	13823
Physi	cian	1. Decedent's Name (First, Middle, L	,				2. Date of D Month	Day		3. Time of Death
/Med	lical	4a. Facility Name (If not institution, gr			th City Town	or Location of De	APRIL			5:30 AM
Exam	iner	HOWARD WUNTY	,			MBIA	eam		County of Death	
Funera	eteris		Sex 7. Age (In yrs. In	ast birthday)	If Under 1 Year Months Days	If Under 24 F	hrs. 8. Date of B	irth		lace (State or Foreign
Directo	ŗ	061-03-9759 Usual Residence of Decedent	1□ M 2 X 1 F 92	Yrs.	Violitis Days	1 louis IV	02/03/		Court	NY
fand ow		10a. State 10b. County	10c. City	, Town or Loca	tion				10	0d. Inside City Limits
Many a-f sh	Director	MD HC	WARD COL	UMBIA						1 ∐Yes 2 No
ith the or 28a e noti		10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Coun	try?
sath w s 23a nust b	eral	5400 VANTAGE POI				21044			USA	<u> </u>
Nnd 21215-0036 be flied within 72 hours after death with the Maryland ntal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	I .	is Decedent of F 'es, specify Cub		(Specify Yes or Nuerto Rican, etc.)	0-	14. Race - America Black, White, e Specify: WH	
15-0	Completed	15. Decedent's 8 (Specify only highest g.	ducation ade completed)	16a. Deceder (Give kir	nt's Usual Occup ad of work done	pation during most of a	working	16b. Kir	nd of Business/Inc	lustry
within ene.	J mc	Elementary/Secondary (0-12)	College (1-4or 5+)	HOUSE		d)			WN HOME	
ified Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Las	t)	110001	-11.4.6	18. Mother's N	Name (First, Middle			
Maryland d 2 should be file th and Mental Hy ?7 is marked othe traumatic event,	To B	LE0		COHEN		REB	ECCA		WEXL	ER
Taryla 2 should and Men is marke aumatic	1.	19a. Informant's Name/Relationship	, , ,	19b. Mailing	Address (Street	and Number or	Rural Route Numi	ber, City or		
		ARTHUR BRODY / S 20a. Method of Disposition		10961	EIGHT B	BELLS LA	NE, COLU			044
MOr Pages nent of I		1 V Burial 2 ☐ Cremation 3	ariemovariioni otate	ace of Dispositi emetery, cremate Ararat	tory or other pla			1	cation - City or To	·
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bernit. Departimont		Jay alax	X				SOL LEVII N ROAD -	NSUN PIKF	a bkus., SVILLE.	INC. MD 21208
	; ·	23a. Part1. Enter tile disease, or con shock, or heart failure. List or	plications that caused the death one cause on each line.							Approximate Interval Between
Physician	-	Immediate Cause (Final disease or condition resulting in death)	a. SEPTIL S	And 4c						Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequ	•						
	ē.	Sequentially list conditions, if any leading to immediate	b. Syttmic Due to for as a consequent		-					
alsi a det	Examiner	Sequentially list conditions, if any leading terms determined to cause. Enter Underlying Cause (Disease or injury that initiated events	•							
be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as a conseque	ence of):						
tificate be e	ledical		▲ d							
£ 5, 60		IF FEMALE:	23c. If yes, outcome pf pregnar	201						
requires that the death cer een signed by the attendin rould be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 □Ec	ctopic pregnancy ther <i>(specify)</i>	y		2	3d. Date of deliver Month	ry Day Year
t the c	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	000	ther (openity)					
S, T		Part II. Other significant conditions	contributing to death but not resul	ting in the unde	erlying cause glv	en in Part I.	23e. Did	tobacco us	se contribute to the	e cause of death?
he law requires has been sign ge 2 should be	ted	DEMENTIA					_ 1 🗆	Yes 2] No 3 ☐ Proba	ably 4 🔀 Unknown
The law ate has be page 2 sh	Completed by	CHAMIC OBSTA	TUTIVE Pulmon	my DI	SINFE?		24a. Was		24b. Were autop	sy findings available apletion of cause of
VII. The iclan: The sertificate actor, pag							perfo 1□ Yes	ormed? 2/\(\overline{\Omega}\) No	death?	2 🕽 No
Siclar sicertification	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 1 Inpatient 2 E		3 DOA Oth		eath (Check only			
g Phy er this	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	3 DOA 28c. Injur	4 Li Nursing	Home 5 ☐ Res 28d. Describe)
Attending Phy ar death. Ector: After this by the funeral d	Certification:	1 Alatural 5 ☐ Pending 2 ☐ Accident investigatio		Injury		k? Yes 2 □ No				
or Atte	riji.	3 ☐ Suicide 6 ☐ Could not be determined		ne, farm, street	, factory, office		28f. Location (City or To	Street and wn, State)	l Number or Rural	Route Number,
pital o		29a. Certifier 1 Certifying P	T- Ab- bask of sell-	I de la la la la la la la la la la la la la						
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s	Medical	(Check only one)	hysician: To the best of my know miner: On the basis of examination and manner stated.	on and/or inves	ccurred at the tir tigation, in my c	me, date and pla opinion, death o	ace, and due to the ccurred at the time	cause(s) a , date and	and manner as sta place, and due to	ated. the cause(s)
To th within To th	Me	29b. Signature and title of certifier			29c. Licens				signed (Month, E	
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10		30. Name and address of person who			nt)	Marie M	A		,	7- Min 2644
	ate	31. Date filed (Month, Day, Year)	Registrar's Signatu	re UTT-L	1/10	7	HOKWAM	1651	ungia	rvin 2044
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State Registrar Spepk MD

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31. Date filed (Month, Day, 'Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Resetrar's Signature

Colores.

DHMH 17 Rev 1/2001

GUPTA 4650 SANTIAGO ROAD

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APRIL 279 2007

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SUITE 110

COLUMBIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend #15, perFH, G867, 578/0 Manyland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year SARAH BENESCH APRIL 28 /Medical 2007 7:40A 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year Months Days Year If Under 24 Hrs.
Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🕱 F Director 215-22-0884 80 09/20/1926 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at Director 1 ☐ Yes 2 No MD MONTGOMERY N. BETHESDA 10e. Street and Number 10g. Citizen of What Country? 5 must be 5801 NICHOLSON LANE, #235 2**3**a 20852 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian other traumatic event, the Medical Examiner Black White etc. illed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE Specify. þ 3 Widowed 4 Divorced Specify: "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TEACHERS AIDE **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 Is marked ot any injury or other traumattc even and 2 should be a BENJAMIN **JAPKO** 2 MIRIAM SCHWARTZBERG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES BENESCH / HUSBAND 5801 NICHOLSON LANE, #235, N. BETHESDA, MD 20852 20b. Place of Disposition (Name of complete gramatory of other place)
AMUNO CONGREGATION 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/30/2007 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ATHEROSCLEROTIC CORONARY ARTERY DISEASE disease or condition resulting in death) YEARS /Medical Due to (or as a consequence of): Examiner RENAL FAILURE YEARS Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine PERIPHERAL VASCULAR DISEASE YEARS Due to (or as a consequence of): physician Physician/Medical the l as 1 IF FEMALE: nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy ρ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed has been Was a. autopsy performed? 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 : death? 1 ☐ Yes 2 ☐ No certificate Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2X No 2 1 X Inpatient 2 ER/Outpatient 3□ DOA 0 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. certifier < 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

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HORVATH, KEITH
State 31. Date filed (Month, Day, Year)

8600 OLD GEORGETOWN ROAD, BETHESDA, MD
82. Registrar's Signature

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

2007

Registrar

062283

04/28/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene

Cortificate of Device Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 30 A M LEN 2007 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TIMORE 5. Social Security Number 7. Age (In yrs. last birthday) r 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 K F Months Days Hours **Director** death with the Maryland 10a. State show 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits **Funeral Director** 1 XYes 2 □ No TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced Jac (Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death P.O. the detached 9□Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform Division or Vital 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 Denpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manne eath 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year,

Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month -8:35рм **Physician** Denise Conway therine 2007 /Medical (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner NIA alt ΠO If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Se (In yrs! last birthday) Social Security Number Funeral Min. Months Days Hours 1 □ M 2 💢 F 214 • 76 • 2248 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Bathmore MD 1 XYes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21239 Wulters Avenue Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ould be filed within 72 hours after Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Clerical 12th grade Keceptionist 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Conwar Geraldine Simmons C0 ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Mother Belveder Avenue MD Anthony mportant; If item 27 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Injury or 1 XBurial 2 □Cremation 3 □Removal from State Window Mill, MD 05/07 4 ☐ Donation 5 ☐ Other (Specify) C. Greene Funeral SNCS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn York Road Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ntrac Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine cords, P.O. Box 68760, requires that the death certificate be executed the burial-transit and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an has page 2 autopsy performe 2 No 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 KInpatient 2 ER/Outpatient 3□ DOA this within 24 hours after death.

To the Funeral Director: After this completely filled in hour. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) çause of death (Item 23a) (Type, Print) Olfe Street, 0 600 31. Date filed (Month, Day, egistrar's Signatur State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 200° **Physician** ORMAN COLLINS 08.05AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown, Bultimore, MD

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) Baltimore Northwest Hospital Center 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 58 Yrs. 217-50-5380 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or Items 23a or 28a-f show cheal Examiner must be notified at Sykesville 1 ☐ Yes 2 ☑ No Carroll County Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 217847123 702 **Funeral** 14. Bace - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☑ No Specify. δ 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hc
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natur.
any injury or other traumatic event, the Medical once. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) heavy equipment operator construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Howard Collins Sr. Marianna Henson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharion Collins (spouse) 7702 Gaither Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/2/2007 White Rock UMC Cem. Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dauge Hought Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Advanced Small cell Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending plant of the last IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Linknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ellulus 2 No 3 Probably 4 Dinknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page 2 certificate has 1∐ Yes 3 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 2 No 1 Impatient 2 ☐ ER/Outpatient Certification: To funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24

5

State Registrar

31. Date filed (Month, Day, Year) MAY 0

29b. Signature and title of certifier

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Parties

Retties 32 Registrar's Signatur

29c. License number

2007

29d. Date signed (Month, Day Year)

Kamahvanu

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / State Registrar		rtment of H tificate of I			ne _{No.} 2 ()	07	13830
	Physicia	_	1. Decedent's Name (First, Middle, Last) Burton L. Cordry			•	2. Date of Death	27	2007	3. Time of Death 8:00 a M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4205 Manor View Road		4b. City, Town, or Glen	Location of Death		4c. County Bal	y of Death timor	e
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 1 1 1 2 1 5 1 8 3	birthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y)	923	9. Birthp Cour M153	olace (State or Foreign otry)
	το	ı	Usual Residence of Decedent 10a. State 10b. County 10c. City, To						1	0d. Inside City Limits 1 ☐ Yes 2 ☐ YNo
	with the Maga or 28a-f	I Director	MD Baltimore (10e. Street and Number 4205 Manor View Road	Glen	10f. Zip Code 21057		10g.		What Cour	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral	11. Marital Status 1 Never Married 2 Married In Image In	т	Vas Decedent of H Yes, specify Cuba □ Yes 2☑ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - Americack, White,	etc.
Maryland 21215-0036	n 72 hours "natural", edical Exa	Completed by	3 □ XWidowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	6a. Decede	ent's Usual Occup		ing		Business/In	Jhite dustry
Z1Z p	filed withi Hygiene. Ither than	Comp	Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)		ineer		e (First, Middle, Ma	Avior		
rylan	d Mental narked o	To Be	Earl Edmond Cordry	Ob Mailia	- Add (CAA	Dorot		NA	Bool	
	and 2 sh ealth and n 27 is n her traun		Karen Ruth Cordry-daughter	1070	5 Torran	ce Dr., S	al Route Number, C Silver Spr	ing,	MD 2	20902
altimore,	Pages 1 ment of H ant: If Iter		ceme	etery, crem	sition (Name of natory or other place Grove Pr	esb. 05/0			- City or To	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee						1	
	Physician /		23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	6E	-04			/	e	Approximate Interval Between Onset and Death
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,	ficate be executed physician and s the burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause)	ana	liomy o,	pathy			-	yes
58760,	ficate be physicial s the buri	dical	. Hypertensie	020						YRS
.O. Box (The law requires that the death certifii ate has been signed by the attending I bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal deaded the pregnant at time of death 9 ☐ Unknown	ath 3]Ectopic pregnanc]Other <i>(specify)</i> _	у			ate of deliv	ery Day Year
О.	quires that en signed by uld be deta	ed by Ph	Part II. Other significant conditions contributing to death but not resulting DEMENTIA, OTTIAL TIBELLI	g in the un	nderlying cause giv	ven in Part I.	23e. Did toba	cco use co 2 ☐ No	ntribute to	the cause of death? bably 4 Municipal July 1 Management 1
al Records,	8 S S	Completed by	Chronic Renal Failure	Hy	perlipia	lemja_	24a. Was an autopsy performe 1 Yes 2		o. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
or Vital	To the Hospital or Attending Physician: The lythin 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	n: To Be	27. Manner of Death 28a. Date of Injury 28	/Outpatien Bb. Time of Injury		ner: 4 🗆 Nursing H	th (Check only one) ome 5 Resident 28d. Describe how			fy)
Division or	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of injury - At home building, etc. (Specify)		M 1□	Yes 2 □ No	28f. Location (Stre City or Town,	et and Nun State)	nber or Rui	al Route Number,
_	ne Hospital 124 hours a ne Funeral i letely filled	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowler and manner stated.	dge, death and/or in	n occurred at the ti vestigation, in my	ime, date and place opinion, death occu	, and due to the cau rred at the time, dat	se(s) and re e and place	manner as e, and due	stated. to the cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier Relling M.	MI	29c. Licens	5474	9 /12	Date sign	ged (Month	, Day, Year) 2007
	1071		30 Name and address of person who completed cause of a (Item 23)	(Type,	Print)	uss Ra	ed, But	timo	1e,1.	MZIZZ8
6	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 1 - 2007	Cosse						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar		artmer rtificat					Reg. No.	007	13831
	Physicia /Medic		1. Decedent's Name (First, Middle, Las Ellis David Clark						i	2. Date of De Month April 2	Day	007	3. Time of Death
1	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	f Death		4c. C	County of Dea	ath
g .		-00	Bel Air Health an			Be1		If Under 2	04 Wrs	0.0		rford	
	Funeral Director		5. Social Security Number 6. Social Security Number 1	9x 7. Age (<i>In yr</i> s. ▼ M 2□ F 89	iast birthday) Yrs.	If Unde Months		Hours	Min.	8. Date of Bir (Month, Da)ct. 28	y, Year)	C	rthplace (State or Foreign country) 1abama
	Due A		Usual Residence of Decedent 10a. State 10b. County	10c. C	ty, Town or Lo	ncation							10d. Inside City Limits
	death with the Maryland me 23a or 28a-f show r invest be notified at	tor	Maryland Harford		1 Air								1 ☐ Yes 2X No
	r 28a	rec	10e. Street and Number			10f. Zij	Code				10g. Citiz	en of What C	Country?
	23a o	al D	1336 Saratoga Driv	<i>r</i> e		210	14				U.S.	Α.	
920	be filed within 72 hours after death with the Marylan Hygiene. Hygiene. At Hygiene. Ad other than "natural; or iteme 23a or 28a-f show event, the Medical Exacultar must be notified at	by Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	J.S. 13.	Was Dece If Yes, spe 1 ☐ Yes			gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		4. Race - Am Black, Wh Specify: Wh	
2 I 3-0030	nin 72 hou Medicel E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		16a. Dece (Give	dent's Usu kind of wo DO NOT	al Occupa ork done o se retired	ation furing most	t of workir	ng	16b. Kin	d of Busines	s/Industry
7	od with giene er tha	E O	12	College (17401 34)	Utili	ty Su	perv				BGE		
Maryland	uld be file Aental Hy rked oth tic event	To Be (17. Father's Name (First, Middle, Last) Henry Clark							(First, Middle 1gham	, Maiden S	Sumame)	
Mary	nd 2 shor Ith and N 27 ie me rtreuma		19a. Informant's Name/Relationship (Timothy Clark (Son	67		•				r, MD			Zip Code)
ore,	permit. Pages 1 and 2 should bef Department of Health and Mental I importent: if item 27 is marked of any injury or other treumatic evegace.		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐	20b. Removal from State	Place of Disponentery, cre	osition (Na matory or	me of other plac	e)	D	ate	20c. Loc	cation - City o	or Town, State
baltimor	artmer artmer ortent injury		4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Ligar		yview								Maryland ne of Bel Air
n	Department and police		Alle										21014
	Physician		23a. Part1. Enter the disease, of com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the dea one cause on each line. Cardiopulmo	ath. Do not en	iter the mo	de of dyin					,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a conse	quence of):								2 Weeks
8/00/2 1/4	rate be executed hysician and the burial-transit	Ical Examiner	and the standard of an interest of the cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	c. Due to (or as a conse									
O. Box 6	The law requires that the death certificate ate has been signed by the ettending physpage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preging the large state of	tal death 3	□Ectopic p					2	23d. Date of d Month	lelivery Day Year
rds, P.	w requires that the base by should be detact	þ	Part II. Other significant conditions of Prostate Cancer		sulting in the	underlying	cause giv	en in Part I.			tobacco u	,	to the cause of death? Probably 4 □Unknown
Division of Vital Records,	Physician: The law re this certificate has be al director, page 2 sh	Completed								24a. Was auto perf 1 \(\text{Yes}	psy ormed?	24b. Were prior to death'	
Z Z	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Managari.			0.4			(Check only			
0	Physi this al dir	-T	1 ☐ Yes 2 💹 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 I 28a. Date of Injury	ER/Outpatie					ne 5 Res 28d. Describe			pecify)
o	ding f th. After funer	tlon	1 XNatural 5 Pending 2 Accident investigatio	(Month, Day Year)	Injury	м	28c. Injur Wor	k? Yes 2□		zod. Describe	riow irijar	y occurred	
Divisi	or Attending after death. I Director: After d in by the funer	Certification:	3 Suicide 6 Could not b 4 Homicide determined	O Diese of leive.	home, farm, s	treet, facto	ry, office				(Street and own, State)		Rural Route Number,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medicai C	29a Cartifier 1 X Cartiying P (Check only 2 Medical Example)	nyulcian: To the best of my k miner: On the basis of exami and manner stated.	newledge, dea nation and/or i	ith secure investigation	at the tr	na, date ar pinion, dea	ath occurr	and due to the ed at the time	caus (s) , date and	and macher place, and d	as stated. lue to the cause(s)
Ł	To the within To the comp	Me	29b. Signature and title of certifier			2	c. Licens	e number				1	onth, Day, Year)
				I wo.			D006	3981			51	1/200	7.
	10		30. Name and address of person who Benjamin Lee,	MD 669 Revolut	ion St	. Hav	re d	e Gra	ace,	MD 210	78		
Salar Salar	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0	1 2007	nature &	Apa	K)						

			State of Maryland / Department of Health and Mental H	•	
			1 - State Certificate of Death	Reg. No.	13832
	Physicia	an	1. Decedent's Name (First, Middle, Last) Delores Lorraine Colbert Month	Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1 26, 2007 4c. County of Dea	01:40 A M
	LXdiiiii	ÇI	GREATER BALTIMORE MEDICAL CENTER TOWSON	BALTIMO	RE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Education (Months) 1 Months Days Hours Min. 5 -	Birth 9. Bir Day, Year) C	rthplace (State or Foreign
	Director		Usual Residence of Decedent	13-1934	MD
	arylan ehow	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1X Yes 2 □ No
S	rith the Ma or 28a-f	ecto	MD NA Baltimore 106. Street and Number 10f. Zip Code	10g. Citizen of What C	
Q.	death with the Maryland ms 23s or 28s-f ehow rmust be notified at	Funeral Director	1809 N. Bond Street 21213	USA	outing.
S	r deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - Am Black, Whi	
36	rs afte	by Fi	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No I Yes, Give 1 □ Yes 2 ☐ No Specify: Year or Dates:		Black
5-0036	within 72 hours after ene. "natural", or ite na Madical Examina	ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working	16b. Kind of Business	s/Industry
21,	vithin 7 ne. han "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	John Hop	
d2-	filed v Hygie other t	CO	12th grade NA Lab Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)		ıcy
\propto	Aental Aental rked c	To Be	Alfred Edward Johnson Emma Scott		
BER	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num 19c. 19c. 19c. 19c. 19c. 19c. 19c. 19c.		
	1 and Health em 27 other t		Beatrice Fleming -Daughter 714 Kahn Drive Pikesvi	ille, MD 2	
COL altimore,	Peges ent of nt: If it ry or o		Ty Burial 2 Cremation 3 Removal from State 4 Donatige 5 Other (Specify) Cemetery, crematory or other place) Garrison Forest Vet 5-3-0		Mills, Md
	permit. I Departm Importal eny Inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility March		milib) na
<u> </u>	89 = 9		Brayellallan 1101 E. North Aver		1
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Pulluouan Eugo Grand Cura and Consequence of State Consequence of State Cura and Consequ		
	Examiner				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
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B	death a atten d for u	ician	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Yes No. 4 Pregnant at time of death 5 Other (specify)	23d. Date of de Month	Day Year
O. O.	at the	Phys	9 L Unknown		
, Division of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certificate redath. ector: After this certificate hes been signed by the attending phys by the funeral director, pege 2 should be detached for use as the	Completed by Physician/Medi	-Dane lailing	d tobacco use contribute t Yes 2 XNo 3 □ P	to the cause of death? Probably 4 Dunknown
COL	w requ	etec	- Shock 24a.W	7	autopsy findings available
Re	The la	gmo	au	topsy prior to progred? prior to	completion of cause of
/ital	clan: ertifica ector. p	Be	25. Was case referred to medical examiner? 26. Place of Death Check on		3 20110
of `	Physi r this c ral dire	- T	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Cher: 4 Nursing Home 5 Re 27. Manner of D ath 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describ	esidence 6 Other (Space how injury occurred	ecify)
ion	nding ath. r: Afte e fune	ation	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2 Accident investigation 28d. Describ	a now injury occurred	
i×is	r Atte ter dea irecto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location	n (Street and Number or F Town, State)	Rural Route Number,
1	pital o	Ce	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the control of the c		
(7)	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes bompletely filled in by the funeral director, page 2	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the one)	ne cause(s) and manner a e, date and place, and du	is stated. ie to the cause(s)
	withii To th	ž	29b. Signature and title of certifier 29c. License number	29d. Date signed (Mon	ith, Day, Year)
	3		10 Name and address of access who completed access of death (then 270) Too British	4/20/6	1/
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE BEDON D 6701N Charles St. Palfo 31. Date filed (Month, Day, Year) MAY 0 1 2007 32. Registrar's Signature	Dd. 212	204
A	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 1 2007 32 Registrar's Signature		
	negisti	या	MAI O T COOL PARTY		

		1	For	artment of Health and Men rtificate of Death	ntal Hygien Reg. No	/ 1111 / 1313	3
7.	Physicia	an	Decedent's Name (First, Middle, Last)		Date of Death Month Da	3. Time of Death	M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Bayview Hospital	4b. City, Town, or Location of Death Baltimore	40	c. County of Death	
9	Funeral Director		5. Social Security Number 251-12-8796 G. Sex 1 M 2 F 82 Vrs. Vsual Residence of Decedent	If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth (Month, Day, Year 6-17-19	9. Birthplace (State or Fore Country) N.C.	ign ——
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Director	10a. State 10b. County 10c. City, Town or Lo MD NA Baltim 10e. Street and Number 3048 Mayfield Avenue		10g. C	10d. Inside City Limi 1½∏Yes 2☐1 itizen of What Country? USA	
9036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if Health and Mental Hyglene with them 27 is marked other than "natural", or items 23a or 28a-if show then traumatic event, the Medical Examiner must be notifiled at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Sive Year or Dates:	Uwas Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 □ Yes ※□ No Specify:	an, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black	
d 21215-0036	filed within 72 h Hygiene. other than "natu ent, <u>the Medical</u>	e Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired) e's Assistant 18. Mother's Name (Fi	B Ho	Kind of Business/Industry Bon Secours Dispital en Surname)	
Maryland	should be inc Mental in arked c	To Be	Warren Spell	Rosa Lan			
altimore, Mar	m O L		Bettie Brown-Daughter 3048 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State	Mayfield Avenue sistion (Name of matory or other place) morial Pk 4-27-	Balto 20c. I	o, MD 21213 Location - City or Town, State	
Balti	permit. Page Department Important: II any Injury o		21. Signature of Fundal Service Licensee 2:	2. Name and Address of Facility Mar 1101 E. North Av	ch F/H enue B	East Balto, MD 21202	
8760,	Physician /Medical Examiner physician and physician sthe prival-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	accest otic vascular		Interval Between Onset and Death	
O. Box 6	ath certif attending for use as	Physician/Medic		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
σ.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the Chonic Pulmonay obst	inderlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown	
or Vital Records,	The la ate has page 2	Completed	Diabetes Mellitus		24a. Was an autopsy performed? 1□ Yes 2□		able of
Division or Vita	Attending Physication: death.	Certification: To Be	25. Was case referred to medical examiner? 1	of 28c. Injury at Work? M 1 Yes 2 No	5 Residence	and Number or Rural Route Number,	
_	Hospita 4 hours Funeral tely filled	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	at the time, date a	and place, and due to the cause(s)	
	To the within 2 To the complete	Σ	29b. Signature and title of certifier T. Mikdashi rmp	Dougso46	4	Date signed (Month, Day, Year)	
9	3		30. Name and address of person who completed cause of death (Item 23a) (Type T. M. Kdashi, 1000 Cudw	del street. Bo	elt M	(D 51501	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 1 2007 32. Registrar's Signature	Print) dral street. Bo			

			For State Registrar	State of Ma	aryland /		artment rtificate			and M		Reg. No 2 U	07	13834
-02	Physici	an	1. Decedent's Name (First, Middle, La	,		_					Date of De Month	Day	Year	3. Time of Death
-	/Medic			etty		Chase					April		2007	02:55 M
يواد ۾ هر	Examin	er	4a. Facility Name (If not institution, give Laurel Regional	e street and number)			_		Location of	of Death		4c. County		
			5. Social Security Number 6. 9	7 40	e (In yrs. last	hirthday)	Laur If Under		If Under	24 Hrs.	8. Date of Birl	th	,	place (State or Foreign
П	Funeral Director			1 ☐ M 2 ∏ F	70	Yrs.	Months	Days	Hours	Min.	(Month, Da Aug • 2	6,1936	Cou	ntry) MD
-	continuent our section		Usual Residence of Decedent					-	l					
	yland Iow		10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits
	Mar a-f st	핝	MD Anne Ar	unde1	Sever	n								1 □ Yes 2 No
	or 28	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	ntry?
	th wi	a	319 burns Crossi	ng Road			2	1144				U.S.A	Α.	
	r dea ems	nei	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Deced	lent of Hi	ispanic Ori an, Mexicar	gin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	- 14. Ra	ce - Ameri ack, White,	can Indian, etc.
9	or it	Ę,	1 Never Married 2 Married	1 ☐ Yes 2 📉 If Yes, Give	No		1 ☐ Yes 2						ty: Wh:	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:	- 1	Sa Dass	deede 1 leve	100000	ation.					
7	"nat	Completed	15. Decedent's E (Specify only highest gr			Give	dent's Usua kind of wor DO NOT us	rk done d se retired	auon <i>during mos</i> i)	t of workir	ng	16b. Kind of E	ousiness/ii	loustry
12	withii ene. than he M	m.	Elementary/Secondary (0-12)	College (1-4or 5			naker		,			Own Ho	me	
9	e filed al Hygid l other vent, tl		17. Father's Name (First, Middle, Las	t) "s. shreened					18. Mothe	er's Name	(First, Middle,	Maiden Surna		
an	ld be ental ked c	To Be	Charles F. Stincl						Mar	y T.	Donald	lson		
Maryland	should be and Mental s marked o umatic eve	-	19a. Informant's Name/Relationship	(Type. Print)	1	9b. Mailir	ng Address	(Street				er, City or Town	, State, Zi	p Code)
	d 2 Tip		Mr. Mark S. Chase	e/Son		1217	Guil	fore	d Roa	d Gle	en Burn	ie, MD	21060)
Je,	of He of He litem		20a. Method of Disposition	7D 01-1-	20b. Place ceme	of Dispo	sition (Nan	ne of ther plac	e) :	May	ate 3	20c. Location	- City or T	own, State
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 3 any injury or other		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont		l	Have	en Mei	m.Pa	rk	200	7	Glen 1	Burni	e. MD
aĦ	permit. Departn Importa any inju		21. Signature of Funeral Selvice Lice	ensee	M0141	1 22	2. Name an	d Addres	ss of Facilit	^{ty} Sin	gleton	Funera.	l Hom	e. P.A.
<u> </u>	8 3 E 8		1 KT Julian	_		1	Seco	na A	venue	: SW	Gren Bi	irnie, N	MD 21	061
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Hemorrha	agic Br	ain				cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	Medical Examiner hysician and the burial-transit	Jical Examiner	Sequentially list conditions, and a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Bacterer Due to lor as	a consequence a consequence a consequence	ce of							2	
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3	⊒Ectopic pr ⊒ Other (sp		/				ate of deliving	very Day Year
<u>α</u>	s that ned b	by Pr	Part II. Other significant conditions	contributing to death b	ut not resultin	g in the u	inderlying c	ause giv	en in Part l	l.	23e. Did	tobacco use cor	ntribute to	the cause of death?
Records,	w requires been sign should be		Aortic Stenoses	- Severe							1 🗀	Yes 2₩ No	3 ☐ Pro	bably 4 ☐Unknown
ပ္ထ	aw re is bee 2 sho	Completed	Diabetes Mellitu	S							24a. Was		. Were aut	opsy findings available ompletion of cause of
æ	The law cate has page 2 s	mo										ormed?	death? 1 ☐ Yes	2 □ No
Vital		Be C	25. Was case referred to medical					East	26. Place	e of Death	(Check only			
r	di is	To E	examiner? 1	Hospital: 1X Inpati	ent 2 ER/	Outpatie	nt 3□ DC	Oth	er: 4□ No	ursing Ho	me 5□Resi	idence 6 □O	ther (Spec	ify)
n or	ding Pth n. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28 ay Year)	b. Time o	of 2	28c. Injur Wor	y at k?		28d. Describe	how injury occu	irred	
30	Attending r death. ector: After by the fune	ăţi	2 ☐ Accident investigation				М	1 🗆	Yes 2					
Division	tal or Att s after de al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	20e. Place of in	jury - At home tc. <i>(Specify)</i>	, farm, st	reet, factory	y, office			28f. Location (City or To	Street and Nurr wn, State)	nber or Ru	ral Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifler 1 ☑ Certifying P (Check only 2 ☐ Medical Example)	Physician: To the best aminer: On the basis of and manner st	of examination tated.	and/or ir	nvestigation	n, in my o	opinion, de	ath occur	red at the time	, date and place	e, and due	stated. to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	MICA.	11		290	c. Licens	e number			29d. Date sign	ed (Month	, Day, Year)
	- 1		Mmy	111 Um	-/1/	/		D.	>153	31		Apr	112	1,007
	2		30. Name and address of person who	completed cause of	death (Item 23	a) (Type,	Print)	130	ST	La	uvel, 1	Apr Apr 4D 20	707	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	2007 32. régist	rar's Signature	A	park	3			/			

		•	For State Registrar	State of Marylan		artment of F rtificate of			jiene	7 13835
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	_	3. Time of Death
A PORT	Physici /Medic Examin	al	DOROTHY DO	LORES CARRO	OLL	4b. City, Town, o	r Location of Death	April	27, 2007 4c. County of De	6:30 P. M
E.	LAGIIII			Apt. 102			onium		Balt.	imore
4	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9 B	irthplace (State or Foreign
5	Director		Usual Residence of Decedent	□ M 2 🖫 F 83	Yrs.		Tiodio Milli.	Oct. 19	, 1923 Was	hington D.C.
	ne Maryla 8a-f shov otifled at	Funeral Director	10a. State 10b. County Maryland Balti		y, Town or Lo	Lum				10d. Inside City Limits 1 ☐ Yes 2 ▼No
	with the	ä	10e. Street and Number			10f. Zip Code		,	log. Citizen of What (,
	eath is 23	eral		Apt. 102 12. Was Decedent Ever in U.	C 13		21093	nocify Vos or No	U.S.A.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	호	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Puert	o Rican, etc.)	Black, Wh	
9	72 hou	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation	deine	16b. Kind of Busines	s/Industry
21215-0036	filed within 7 Hygiene. Ither than "r	Completed	(Specify only highest gra	College (1-4or 5+) 2 years	life.	kind of work done DO NOT use retire Realtor	during most of word)	King	Real Est	ate
b	other other	Be C	17. Father's Name (First, Middle, Last)			HOULEGE	18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
Maryland	12 should be fi h and Mental H 7 is marked ot traumatic ever	To E	Robert Thomas C	reel			Anna	Brad	ley	
lan)	2 sho and I is ma		19a. Informant's Name/Relationship (7	Type. Print)	19b. Maili	ng Address (Street	and Number or Ru	ıral Route Numbe	r, City or Town, State	, Zip Code)
	Health Health tem 27 i		Kevin F. Carroll	(son)		Bullock	Drive O		lls, Maryl	
Ore	a c = =		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐	Removal from State	emetery, cre	sition (Name of matory or other pla		Date	20c. Location - City	or Town, State
Baltimore,	t. Pa rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify) Gre		unt Crema	-	1-07	Baltimore,	Maryland
Bal	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licen	Ferresse	I I	2. Name and Addre Mitchell- 5500. York	Wiedefeld Road B	d Funera	l Home, In Maryland	.c. 21212
	A)		23a. Part 1. Enter the disease or com shock, or heart failure. List only	plications that caused the death	h. Do not en	ter the mode of dyi	ng, such as cardia	or respiratory ar	rest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC Due to (or as a consequ	AR	CHYTH				Onset and Death MINUTES
	Examiner					ILLATTO	241			5 YEARS
		ē	Sequentially list conditions,	b. Due to (or as a consequ	uanes of):	/ LL P4 / IC				MANY
8760,	The law requires that the death certificate be executed tee has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	dical Examiner	day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. HUPERTE Due to (or as a consequent		N		_		YEARS
9	ertificate ing phys e as the	Medi	IF FEMALE:							
O. Box	he death certific the attending pl ched for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	aldeath 3[⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23d. Date of o Month	lelivery Day Year
σ.	res that the de iigned by the be detached	h h	Part II. Other significant conditions of	ontributing to death but not resi	ulting in the L	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	quires n sign ild be	d by	EMBOLIC STR	DKES				1 🗆 Y	′es 2 <mark>X</mark> No 3□	Probably 4 □Unknown
or Vital Records,	The law requir cate has been s page 2 should	Completed	HYPERCHOLES					24a. Was autop	sy prior t rmed? death	autopsy findings available o completion of cause of ?
ta			MILO CHRONI 25. Was case referred to medical	C RENAL II	NSUL	-FICIEI		1 Yes ath (Check only o	22No 1□Y	es 2□No
>	Physiclan: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Oth	ner: 4 Nursing F		lence 6 Other (S	necify)
			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of				ow injury occurred	<i>seeny)</i>
io	Attending ir death. ector: After by the fune	atio	1 Natural 5 ☐ Pending investigation		injury		Yes 2 □ No			
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif		reet, factory, office		28f. Location (S City or Tow	Street and Number or in, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dii completely filled in	Medical (29a. Certifier (Check only one)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, dea ation and/or i	th occurred at the to	ime, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and manner date and place, and c	as stated. lue to the cause(s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier	Nielse	n m	29c. Licen:	8327		29d. Date signed (Mo	
1	6		30. Name and address of person who					R.#206	Towson	J, MD 21204

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
MAY 0 1 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MAry Davis 2007 April 28 4:50p^M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 2102 Whiteford Road HArford Whiteford 8. Date of Birth OCT. 15, 1905 Hungary 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2X F unknown 101 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10b County 10d. Inside City Limits 10a State Harford 1 ☐ Yes 2 No MD Whiteford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2102 Whiteford 21160 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. ☐Yes 2 f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Bencsak Kate Michovlo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11501 Sherwood Road Upper Falls MD 21156 Beatrice Wadkins 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place) Holly Hill Cemetery 5/1/07 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebrovascular accident disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown Month Year 5 ☐ Other (specify) 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Probably 4 □Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Corchary autopsy performed 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

attending physician and for use as the burial-transit certificate be executed P.O. Box 68760, signed by the a Division or Vital Records, should been : page 2 has this certificate To the Hospital or Attending Physician:

funeral

Examiner Physician/Medical ð Completed Be ဥ Certification:

Physician

/Medical

Examiner

Funeral

Director

show

ral", or Items 23a or 28a-f shov Examiner must be notified at

permit. Pages 1 and 2 should be flied within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner one.

Physician

/Medical

Examiner

the

Saltimore, Maryland 21215-0036

death with

Director

Funeral

ģ

Completed

ဂ္

State Registrar

Medical

30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Aly Naguib, MD

29a. Certifier

(Check only one)

29b. Signature and title of certifier

D0059387

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

4/30/2007

Drive

1 Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Suite 203 Forest Hill, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Colgate

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:45 A M April 2007 Emma C. Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months 78 Director 214-22-4190 Oct 17, 1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show ner must be notifled at 1 ☐ Yes 2 🕅 No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 300 Sunflower Drive Apt. 126 21014 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 N No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 27 is marked other than "natural", or iten traumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Bus Aide Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental Lamarteen G. Sisson Minnie A. Martin ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: if Item 27 is any Injury or other traunonce. Diane M. Hebert, Daughter 1903 Norwood Ct. Fallston, Maryland 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 04/27/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor Name and Address of Facility Cremation Society Of Maryland, Inc. <u>299 Frederick Road Baltimore, Maryland 21228</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence) f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been siç , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☐ No 24a, Was an certificate has 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

within 24 hours after geam.

To the Funeral Director: After this (

Registrar

State

DHMH 17 Rev 1/2001

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

î 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D322

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21014

5000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 08:30P M AFRIL 25. 2007 Alice Elizabeth Dennis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Saint Joseph Medical Center Towson Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 💢 F 88 14, 1918 Director 100-16-5771 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Directo MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 120 Homeland 21212 USA Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than ' ury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rueben Samuel Crosby Elizabeth Crosby (maiden name) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beth Beytes, daughter 120 Homeland Ave. Baltimore, MD. 21212 Department of Heali important: if item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04-30-07 West Arundel Crematory Odenton, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ambrose Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as eardiac of espiratory arrest, Interval Between conset and Death. immediate Cause (Final disease or condition resulting in death) **Physician** YEARS ALZHEIMER'S DEMENTIA /Medical Due to (or as a consequence of): Examiner 1 DAY UROSEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed physician ar s the burial-ti Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 21 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy perform To Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: After 5 Pending investigation Injury 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide I 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of partifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

OSLER

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

0

D 7671 0 32. Registrar's Signature D25886

DRIVE TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 🗍 🧻 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JASPER 4:30AM 200, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MOUNT AIRY MARY LAND

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) PLEASANT VIEW NURSING HOME CARROLL COUNTY Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Director 089-16-4930 86 April 28 1920 N.C. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or then "naturel", or Items 23s or 28e-f show the Modical Examinar must be notified at MD NA BALTIMORE 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5629 CADILLAC AVENUE 21207 Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in the death and Mental Hygiene. At: If item 27 is marked other then "naturel", or itel 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK þ 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12th Transportation Authority New York City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ည ARCHIBALD DILDY ISADORA KNOWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health Sheila Dildy - Daughter 5629 Cadillac Ave. Balto., MD other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) King Memorial Park May 2, 2007 Randallstown, MD 21. Si maturé of Funeral Service Licensee Name and Address of Facili 22. Name and Address of Facility
March Funeral Home West, Inc. 4300 Wabash Ave. Balto., MD 21215 enter the my of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the m shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Spratony disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, in your and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be executed gess MMMC to (or as a consequence of) Box 68760 attending physician cai as the Physician/Medi esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. detached the 9 Unknown 9 Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗖 No 1 Yes 2 No 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funeral D 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month Day, Year) 29b. Signature and title of certifier

State Registrar 9501

32. Ragistrar's Signature

Annypolis

Name and address of derson who completed cause of death (Item 23a) (Type, Print)

1421

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 04 DAVIS 2007 12:48 AM RODERICK **20** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BAKIMULE CITY BALIMORE KERNAN HOSDIKAL ΔD If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M 2 F **Funeral** Days Min. Months Hours 384-48-SL31 アロ Director 140 FIUsual Residence of Decedent or 28e-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1

Yes 2□No N.T Cumberland Vineland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code if Health and Mental Hygiene.
Item 27 is marked other then "natural", or Items 23a or other treumstic svent, the Medical Examinar must be: 123 So. 4th Street 08332 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 女 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) National Freight 12th grade NA Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rosa Lee Lindsey 2 Jesse L. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Davis - Wife 775 So. East Blvd Vineland, N.J. 08360 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 호프 1X Burial 2 Cremation 3 Removal from State Importent: I eny injury o once. 4-27-2007 Hopewell Twsp,NJ Cedar Hill Mem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1101 E. North, Aug Delto. Ma Int. Enter the disease, or complications that falsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** " HEAD AS NECK INJURIES WITH COMPLICATIONS resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Naminal Andreas By MEDICAL EXAMINE! Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal deal
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate ha or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred SUASECT DRIVER OF TRUCK STRUCK 28c. Injury at Work? 1 ☑ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: After 1 Natural 5 Pending 11:38 AM within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 700G EE EO 2 Accident 8f. Location (Street and Number of Rural Boute Number City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide LOADWAY IMBUSANE 95- MILE MARKER 6 Hospitel 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04/20/2007 D0046328 cream 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2200 KEWAN DRIVE BALKIMORE MD 21207 31. Date filed (Month, Day, Year)
MAY 0 1 2007 32. Registrar's Signature

Registrar

7-03215 Dorothy Dutton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

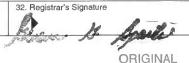
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If the 27 is marked other than "natural", or items 23a or 28a-f show or other tranmatic event, the Medical Examiner must be notified at once.	Funeral	1	Never Marr		Married	Armed Yes Yes, Give Y	Forces?	No		Yes 2			1 30110			Specify:	W	hite
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215-0036 be filed within 7 ntal Hygiene.	ပို		ather's Name	chard	ie, Last) Howa i	d Du	tton							Weinn				
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Baltimore, MD 21215-003 pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. It files 27 is marked other It injury or other traumatic event, the Med injury or other traumatic event, the Med		1 /	Signature of F	1.41	Ta. 1	11/	> M	01305	Rol 30	pert A West	Pui Mon	mphrey tgomer	y Fune Ty Ave	eral Ho enue, R	ne/k ockv	ille, Ma	rylar	d 20850-2805
siciar	_	23a	Part/I/Enter	the disease.	or compli	cations the	at caused th	e death. Do	not enter	the mode	of dying	, such as	cardiac (or respirator	y arrest	, shock, or hea	art	Approximate Interval Between Onset and Death
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, P.O. Box 68 ires that the death certifi signed by the attending	use as	Physician 1	past 12 mor	_			Pregnant at ti	ime of deat	h 5	Other (Sp	ecify)							
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Vita ysicia this cer	· 를	To Be	examiner?	2 No		Hospital: 1	Inpatio		ER/Outpati 28b. Time		DOA 128c I	Injury at W		rsing Home 28d. De		now injury occu		
n of ing Ph	funeral	:u 27	7. Manner of I		Desding	28 a .	Date of Inju (Month, Dey,Y	iry 'ear)	28b. Time	Of Injury	1	Yes 2						
ivision or Attend after death Director:	y the	catic			Pending Investigat	28e	. Place of In	ijury - At ho	me, farm,	street, fact	ory, offic	ce building	g, etc.		ation (S		nber or F	Rural Route Number, C
Divis al or /	led in b	Certification:	Suicide Homic		Could no determine	ed (Sp	necify)											
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after debug. When the Funeral Director: After this certificate has been signed by the attending.	completely filled in by the	S 2	9a. Certifier 1		ing Physic	cian: To t	he best of m	y knowledg	e, death o	ccurred at	the time	e, date and	d place, h occurr	and due to the and at the time	he caus e, date	e(s) and manr and place, an	ner as st d due to	ated. the cause(s)
To the vithin 2 o the	omple	음 l °	ne) 2	10		er:On the and ma	basis of exa	mination ar	id/or inves			ense num				29d. Date si	gned (A	fonth, Day, Year)
	3	2	9b. Signatur	and title of	centier	11	Y	1				.C.M.E.				April 29,	2007	
4			0. Name\and	1 C	Person wh	contriet	eti cause of	death (Item	23a)							1		
01] 3		l address of p Hogan MD		sistant	edical E	xaminer	111	Penn St	reet, l	Baltimo	re, MD	21201				
	St	ate 3	1. Date filed			000	32. Registr		re	A STATE OF	A.							
Re	gist	trar		MA	V 77	2007	Carr.	Sand with	- P. C.	5								

Registrar

State

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANET V- WOB-HINELY IND JORN W. BARTIMENT ST., BALTIMENE MO 21273

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland / [Department of Health and	Mental Hygier	ne 2007	1301.3
	ű.		Registrar 1. Decedent's Name (First, Middle, Las	(t)	Certificate of Death	Reg. I	No. 4 0 0 1	3. Time of Death
	Physici		Evelyn	Edmands		April 2	Day 5007	5'02 M
	/Medio		4a. Facility Name (If not institution, give	e street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death	2100
	i di Managanananan	Şt.	Gilchrist N	ursing Center	Towson		Baltin	nore
	Funeral Director		5. Social Security Number 6. S	mu alth-T and i	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	9. Birthpla	ace (State or Foreign
×.a	D		Usual Residence of Decedent	7 0.7		1400:17,1	122 Mai	ylaria
	arylan show d at	ī	10a. State 10b. County	10c. City, Town	11:		10	ld. Inside City Limits 1 Yes 2 No
	the Mi 28a-f	ectc	10e. Street and Number	ba	10f. Zip Code	100	Citizen of What Countr	, ,
	death with the Maryland ims 23a or 28a-f show r must be notified at	l Di	2201 Frie	JOIN AUD	21211	109.	11 S A	· ·
	ems 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	ipecify Yes or No-	14. Race - America Black, White, e	
36	72 hours after natural", or ite lical Examine	by Fu	1 □ Never Married 2 🕱 Married 3 □ Widowed 4 □ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	o riiodii, cic.	Specify: D /	10.
5-0036	2 hour	ed b	15. Decedent's Ed		Decedent's Usual Occupation	166	. Kind of Business/Indu	LC K ustrv
215	thin 7; e. an "n	nple	(Specify only highest gra	de completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	rking	A A . / A	·
12121	led wi tygien her th nt, the	Con	17 Fatharia Nama (Finat Middle Lant)		CIERK	on (First Middle Marie	MIVA	
Maryland	d be fi ental H ced ot c eve	To Be Completed	17. Father's Name (First, Middle, Last)	a de u	Ross of the street stre	ne (First, Middle, Maid	luland	
ary	shoul and M s mart umati	۲	19a. Informant's Name/Relationship (Type. Print) (Hysband) 19b	. Mailing Address (Street and Number or Ri	ural Route Number, Cit	ty or Town, State, Zip (Code)
	and 2 ealth a n 27 i		Mr. Spencer	Fumonas 75	301 Fairview	Ave. P	alto.Md	.21216
lore	iges 1 nt of H : If iter or oth		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	Removal from State	Disposition (Name of ry, crematory or other place)	, / .	Location - City or Tow	·
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show wayl injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer		150n Forest 7/8		wings Mi	
Ba	permit. Departr Importa any Inji	. 1	Daroph	L. Russ	Joseph L. Russ	Funeral	Home P. A.	7.16
			23a. Part Enter the disease, or com should or heart failure. List only	plications that caused the death. Do rone cause on each line.	not enter the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between
Y.	Physician		Immediate Cause (Final disease or condition resulting in death)		2 procin om a constitution of: prim my		noun	Onset and Death years
100	/Medical Examiner		resulting in death)	Due to (or as a consequence of	of): prim my)site		0
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	bDue to (or as a consequence of	of):			
$\sqrt{}$	executed n and ial-transit	Examiner	Cause. (Disease or injury that initiated events resulting in death) Last	c				
60,	ficate be executed physician and s the burial-transit	a E	resulting in death, East	Due to (or as a consequence of	of):			
68760,		edical		d				
Вох	eath certif attending for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death	3 □Ectopic pregnancy		23d. Date of deliver	y
	The law requires that the death cert tee has been signed by the attending age 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)		Month E	Day Year
P.0	ires that the de signed by the a t be detached t		Part II. Other significant conditions c	ontributing to death but not resulting in	n the underlying cause given in Part I.	23e, Did tobacc	o use contribute to the	e cause of death?
rds	quires n signo	d by					2 ☑ No 3 ☐ Proba	
000	aw requir is been si 2 should b	olete				24a. Was an	24b. Were autop	sy findings available
E B		Completed				autopsy performed 1 Yes 2 ☐	2 death? No 1 ☐ Yes 2	pletion of cause of 2 □ No
Vita	Physiclan: r this certificaral director, I	Be	25. Was case referred to medical examiner?	Hospital:	Othor	ath (Check only one)		. 1
ō	Phy rald	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury 28b. T		fome 5 ☐ Residence		Hospice
ion	inding Fath. r: After ie funera	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Time of njury at Work? M 1 ☐ Yes 2 ☐ No		gary coounica	,
Division or Vital Records,	I or Attencathatter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, St.	and Number or Rural	Route Number,
Ω	pital o		29a. Certifier 1 CertifyIng Ph	veician. To the best of my knowledge	, death occurred at the time, date and place	and due to the severe	(c) and manner on at-	*
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune fune	Medical	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	d/or investigation, in my opinion, death occi	urred at the time, date	and place, and due to	the cause(s)
	To th Withii To th	ž	29b. Signature and title of certifier	1 1-0	29c. License number		Date signed (Month, D	
	α		1/1 Hvd	hong Mily:	Type, Print) N. Charles	11	DY, 127	, 200 ×
	1		30. Name and address of person who	completed cause of death (ftern 23a) (Type, Print) W. Chowles	St. Ral	to md 2	105
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature				
	Registr	ar	MAY 0 1 200	7 Steamer St. Ag				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 24, 2007 4c. County of Dea /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Health 8. Date of Birth Sept. 9 9. Birthplace (State or Foreign Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 💢 F Months Days Min. Yrs. Director Ge Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Md. Baltimore 1 Yes 2 No Director or 28a-f 10g. Citizen of What Country? 10e. Street and Number Examiner must be 23a Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ 3 X Widowed 4 ☐ Divorced natural", Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (daughter) Department of Health a Important: If item 27 is any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses neral Home North Ave. 23a. Part / Enter the decase, or complications that shock, or heart failure. List only one cause on disease or condition resulting in death) Approximate Interval Between Onset and Death used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 206 **Physician** /Medical Due to (or as a consequence of): Examiner Vann Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ysician Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Fctonic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Onknown 1 🗌 Yes 2□ No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate ha 1∐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐ Ho ဂ 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: , I in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 31464 MD

State

DHMH 17 Rev 1/2001

Registrar

N. EUTAW ST SINTE 305

BALTIMURE MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

MI

A.

MAY 01

31. Date filed (Month, Day, Year)

821

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM/6, perFH, G867, 571,07, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** arshell 2007 :0/AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of
5. Social Security Number Battmore HOSPITA Marylan If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1 2 X F **Funeral** Min Months Director Feb 12, 1952 Maryland 215-60-3859 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □¥es 2 □ No Director Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 U.S.A. 421 South Gilmore Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 \ X 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabelle Baxton Richard Baxton ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 South Gilmore Street Baltimore, Maryland 21223 Jasper E. Manning 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Brooklyn Park, Md. 05/05/07 4 Donation 5 Dother (Specify) Cedar Hill Cemetery & Mausoleum Funeral Service/Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician hour acute me /Medical Due to (or as a consequence Examine Sequentially list conditions, if any, leading to infine dut-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for es a nonsequence of). Examiner the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical attending p for use as IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? **≙** Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an has autopsy page ; this certificate 1□ Yes 2 PNo or Vital To the Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 DER/Outpatient 3 DOA P 2∏ No 1 Inpatient 28a. Date of Injury (Month, Day funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 5 Pending investigation Year Division 1 Natural 1 ☐ Yes 2 ☐ No filled in by the fu death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Muca for, wo Attending Physician
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Greene Str 0°1 Year) 2007 32. Registrar's Signature State Registrar

			for State Registrar	State o	f Marylan	-	artment o			Mental H	/gier	ne nn7	13846
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7,	Physici	an	Decedent's Name (First, Middle	,						2. Date of D Month April		Day Year	3. Time of Death
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	r 28a	Director	10e. Street and Number	шегу	ROCI	CATTIE	10f. Zip Cod	ie			10g. (Citizen of What Cou	ntry?
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altimore,	8 = = 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from	State	emetery, crer	sition (Name o natory or other	place)		iPate 28,	20c.	Location - City or T	own, State
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0	ding F h. After funera	틶	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investiga	(Moni	th, Day Year)	Injury		njury at Work? I∐Yes 2	2 ∏ No	Zod. Describe	now m	jury occurred	
DIVISION	I or Atten after death Director:	fica	3 Suicide 6 Could no	t ho	of injury - At ho ng, etc. <i>(Specif</i>)	me, farm, stre				28f. Location	Street	and Number or Run	al Route Number
2	after after Dire	Certification:	4 ☐ Homicide determin	buildi	ng, etc. (Specif)	1)				City or To	wn, Sta	ite)	a riodio rvaribor,
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying	Physician: To the	best of my know	wledge, death	occurred at th	e time, dat	te and pla	ce, and due to the	cause	(s) and manner as s	stated.
	n 24 ho	Medical	(Check only 2 Medical E	xaminer: On the ba	asis of examination and a stated.	tion and/or inv	estigation, in r	ny opinion,	, death oc	curred at the time	, date a	and place, and due t	o the cause(s)
	To the Ho within 24 To the Fu	Me	29b. Signature and title of certifier	**				ense numb				Date signed (Month,	Day, Year)
	1		W/C	100	w		1	005	27	74		4/20/0	17
1	1		30. Name and address of person v	ho completed caus	e of death (Item	23a) (Type, I	Print)		,			, , , , , ,	
1	1		LOU C. 1	ornw	NO		SUBW	LBN	1 1/4	74 SPIM)	5071301	9 M)
	Sta		31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	ture	AP 8						
	Registr	ar	MAY 0 1 20	107 Alexander	is the	Jan 134	3						

			-	-	aryland / D	ера	rtment of F	lealth and l	-		ne	7 3 2 2 1 1
	245		Decedent's Name (First, Middle, Last)						2. Date of De		200	3. Time of Death
	Physici	an	Tonya	Marie	Εn	σe'	lhart		Month	26	Day Year	12:46 a ^M
	/Medic					.60.		r Location of Deatl	April		2007 4c. County of Dea	
).	Examin	er	4a. Facility Name (If not institution, give str		_				Ц	'	,	
	day and a second of the		Gilchrist Center fo			-,)	TOV If Under 1 Year	Vson	Lo. Data of Bi			imore
10	Funeral Director		217-17-2347	7. Ag	e (In yrs. last birtl	rs.	Months Days	If Under 24 Hrs. Hours Min,	8. Date of Bi (Month, Da Aug 3,	ay, Yea	ar) C	thplace (State or Foreign ountry) rginia
	pue w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Lo	cation					10d. Inside City Limits
	sho sho	ř										1 □ Yes 2√2 No
	8a-f	ctc	MD Balti	nore	T	ımo	nium					
	iff to a	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What C	ountry?
	23a ust		117 E Padonia Roa				210				U.S.A.	
	ems er m	Funeral	11. Marital Status	. Was Decedent I Armed Forces?	Ever in U.S.	13. \	Vas Decedent of F f Yes, specify Cub	fispanic Origin? (S an, Mexican, Puer	pecity Yes or Note Rican, etc.)	0-	14. Race - Ame Black, Whi	
ထ	or it	币	1 Never Married 2 Married	1 ☐ Yes 2 【 If Yes, Give	No		I∐Yes 21☑No				Specify:	
<u> </u>	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	l by	3 Widowed 4 Divorced	Year or Dates:				Оросия			Specify.	White
7	72 hg natu	Completed	15. Decedent's Educa (Specify only highest grade of	tion	16a. I	Deced	lent's Usual Occup	oation during most of wor	rkina	16b.	. Kind of Business	/Industry
Ž	hin 7	be	Elementary/Secondary (0-12)	College (1-4or 5		life. L	OO NOT use retire	d)	King			
7	Transfer the the	E O	0		,		N/A				N/A	
ō	be filed within 72 hours after death with the Marylar Hygiene. d other than "natural", or Items 23a or 28a-f show to ther than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle	e, Maid	len Surname)	
<u>a</u>	d be enta ked c ev	To B	Thomas A. Engel	hart				Ma	arie Vau	be1	_	
Maryland 21215-0036	2 should be filed v and Mental Hygie Is marked other t aumatic event, th	-	19a. Informant's Name/Relationship (Type		19b.	Mailir	a Address (Street	and Number or Ri	ural Route Numi	ber. Cit	tv or Town. State.	Zip Code)
<u>s</u>	₽ £ 12 ₽ ₽						. Macpha:		Bel Air		arvland	21047
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		Thomas A. Engelhar 20a. Method of Disposition	t Fathe					Date All		Location - City or	
ò	Pages nent of int: If its iry or o		1 ☐ Burial 2 【XCremation 3 ☐ Re	noval from State	1		sition (Name of natory or other pla					
≝	Entrant:		4 □ Donation 5 □ Other (Specify)		Carrol	-	Cremation		6/07			Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signatur of Suneral Service Licenses	11 0	V -	22	. Name and Addre	ess of Facility	l1824 Re	ist	erstown	
	20 2 9 9		septien 1	" fen	Dans			ral Home			own, MD	21136
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	tions that caused	the death. Do n	ot ent	er the mode of dyi	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician	9.9	Immediate Cause (Final disease or condition					Inde				Onset and Death
41	/Medical		resulting in death)	Due to (or as	a conse juence o			1				00 00 17
	Examiner			,		,						
	OCE.	r e	Sequentially list conditions, if any, leading to immediate causa. Enter Indenying Cause (Disease or injury that initiated events	Due to (or as	a consequence o	f):						
	ted nsit	Ë	Cause (Disease or injury									
	ficate be executed physician and is the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as	a consequence o	f):				-		
760,	be ey cian ouria	calE				-,-						}
	ate hysi		d.									
89 >	death certificate t attending physic I for use as the b	Me	IF FEMALE:			_						
Box	ith ce tend r us	an/	23b. Was decedent pregnant	 If yes, outcome 1 ☐Live birth 	pf pregnancy 2 ☐ Fetal death	3[Ectopic pregnanc	у			23d. Date of de	
	e dea ne at ed fo	sici	in the past 12 months? 1 ☐ Yes 2 Ø No	4□Pregnant at 9□Unknown	time of death	5[Other (specify) _	-			Month	Day Year
P.O.	The law requires that the death certifica lie has been signed by the attending phy page 2 should be detached for use as th	Physician/Medi	9 Unknown									
	aned gned	by F	Part II. Other significant conditions control	ibuting to death b	,		, ,	1	23e. Did	tobacc	co use contribute t	to the cause of death?
ğ	quire in sig uld b	ğ	cerebral pol	my,	sees	16	re de	cr de-	1 🗆	Yes	2 → M 6 3 □ F	Probably 4 ☐Unknown
Records,	w require been sign should b	Completed	4		.)				24a. Was	s an	24b. Were a	utopsy findings available
e	he las has ge 2	ᇤ							auto perl	opsy formed	prior to	completion of cause of
_	ding Physician: The lav h, After this certificate has funeral director, page 2		05.14						1□ Yes	2 🖸	No 1 □Ye	s 2□No
Vital	Attending Physician: r death. ector: After this certifics by the funeral director, p	Be	25. Was case referred to medical examiner?	spital:			t 3DDOA Oth	26. Place of Dea			10.	11
	this all dir	မ	1 Tes 2 140			<u> </u>	. 0000	4 LI Nursing F			6 Other (Sp.	ecitat yacce
<u>_</u>	ng F	Ë	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. T <i>y Year)</i> In	ime oi ijury	Wo		28d. Describe	how ir	njury occurred	9
ပ္က	endi eath. or: A	ati	2 Accident investigation			_	M 1 🗆	Yes 2 □ No				
Division or	or Attencatter death Director: in by the	ij	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injuding, et	ury - At home, far c. (Specify)	m, str	eet, factory, office		28f. Location City or To			Rural Route Number,
5	tal or A s after al Dire ed in by	Certification:									,	
	Hospital 24 hours a Funeral I		29a. Certifier 1. ☐ Certifying Physi (Check only 2 ☐ Medical Examine									
	To the Hospital or within 24 hours afte To the Funeral Diracompletely filled in In	Medical	one)	and manner sta								
	To the within 2 To the Comple	Σ	29b. Signature and title of certifier	1	,		29c. Licens			29d.	Date signed (Mor	nth, Day, Year)
	1		1-// Month	y the	Co .	m	12	5 20's		A	ori(Z	6,2007
1			30. Name and address of person who com	pleted cause of d	eath (Îtem 23a) (Гуре,	Print)	0 1	i n	6	/	26,2007
1)		W.A. Riley	G GAM	C 670	1	N. Ch	inter 1,	T. Ba	KX	s. and	20205
			31. Date filed (Month, Day, Year)	29 Dogiote	ar's Signature	67						

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 13348

orinior E	yriir r aii		For State		-	C	ertificat	te of L	Death_					eg. No.			3. Time of Death
וס. 🖟 ח	hysiciar		gistrar Decedent's Name (First, Midd	le,Last)									Date of Deat Month April 28, 2	Day	Year		0940 hrs
∕le ₹	xamin	er	Jennifer_	Lynn_	Faira	11_		4h	. City, Tov	vn, or Lo	cation of E		ψπ 20, Z	4c.	County o	f Death	1 1
		48	a. Facility Name (if not institute Howard County Gene	on, give stree eral Hospi	et and numbe ital	er)		"	Columb					1	oward		
			Social Security Number	6. Sex		Age (In yr	s. last birth	day)	If Under		If Under 2	_	3. Date of Bi	rth (MM/C	D/YYYY)	9. Birt Foreig	thplace (State or
	ineral rector		213–98–6272	1 M	_ 1		4	Yrs.	Months	Days	Hours	Min.	August	21,	1972	Col	Wash.D.C.
	CCLO	- 1	sual Residence of Decedent	, IVI	2 X '												10d. Inside City Limits
	any		0a. State 10b. County	1			City, Town o		n								1 X Yes 2 No
.		_	Maryland Howa	ard		S	avage	<u> </u>						10a Citi	zen of Wh	nat Cou	
arylar	28a-f show d at once.	Director	0e. Street and Number						10f. Zip (2				ted		
S the M	s 23a or 28a-f show	ä	8536 Storchwo							2076		n2 / Sper	cify Yes or N				rican Indian, Black,
with	ns 23 be no	Funeral	1. Marital Status		. Was Deced	lent Ever i ces?	n U.S.	13. Was	es, specify	Cuban,	Mexican, F	Puerto Ri	ican, etc.)		White	e, etc.	
death	or ite	ij	1 X Never Married 2	1 oivorced of Ye	Yes	2 X N	lo	1	Yes 2	X No	specify:				Specify:	Whi	.te
after	ral",	<u>a</u>	3 Widowed 4 5. Decedent's Education (S			complete	d) 16a. [Docodon	te Ueual C	Occupation	n (Give ki	ind of wo	rk done	16b.	Kind of Bu	usiness	/Industry
hours	'natu Exan	E -	Elementary/Secondary (0-1		College (1-4		— `	-	ost of work	ing lite.	DO NOT U	jse reure	a)	D ₀	estai	ırar	nt
36	than,	ompleted	Licinary		1		\ \ \ \ \ \	Vaitı	ress								
00-	Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	히	17. Father's Name (First, Midd	le, Last)				_		1			First, Middle			2)	
215 5.66	ntal H	Be (Patterson Fai	rall			140	h Mailin	Address	(Street	BOD and Num	bie or Ru	Jean Nural Route N	umber, C	City or To	wn, Sta	te, Zip Code)
77	id Mer is ma	P	19a. Informant's Name/Relation										, Sava	re.M	D 20'	763	
Z	alth an	-	Bobbie J.Fair	all/MC	other_		20h Place	of Dispos	ition (Nan	ne of cer	netery,		Date	20c.	Location	- City o	or Town, State
ē,	SS 2r of Hez If ite her tr		1 Burial 2 X Crema	tion 3	Removal fro	m State	cremat West 2	tory or ot Arun	her place)	rema	atory	May 200	7 3 17	0	dent	on,N	Maryland
Baltimore,	Pagement tant:		4 Donation 5 Other 21. Signature of Funeral Serv	Specify:							1			Mort	uary	Sei	rvices, Inc.
3alt	Depart Depart Impor njury		-///					1 5	O T		0007	Mag	hingt	on D	C	2003	
Bai	sician		23a. Part I. Enter the disease	, or complica	ations that ca	used the	death. Do n	ot enter	the mode	of dying,	such as c	ardiac or	respiratory	arrest, sl	nock, or r	eart	Between Onset a
-	edical		failure. List only one ca	use on each	Mixed d												Beast
Ex	aminer		Immediate Cause (Final dise or condition resulting in deat	n) Du	ie to (or as a	conseque	ence of):										
			Sequentially list conditions,	b	ue to (or as a		neo of):										
		iner	if any, leading to immediate cause. Enter Underlying Ca	use c													
J.		Examine	(Disease or injury that initiat events resulting in death) L.	ast Du	ue to (or as a	conseque	ence of):										
no	icate be executed physician and the burial - transit	Ē		d													
	be exe ician urial -	Medical	XUNPENDED		#23a.2			ME, e	867 , 5	5/16/	97 TT -			- 1	23d. Date	of deli	
760,	icate g	/We	IF FEMALE: 23b. Was decedent pregnant	in the	23c. If yes,		or pregnanc	2 F	etal death	3	Ectop	ic pregna	ancy	1	Month	١	Day Year
89	certif ending use as	sician	past 12 months?		4 Pregr	nant at tim	e of death	5 (Other (Sp	ec <i>ify</i>)				-			
Box 68	death he att	ysi	1 Yes 2 No 9	Unknown	9 Unkn		at a st seculi	ling in the	- underlyir	na cause	given in F	Part I.					e to the cause of death
o.	at the	y Phy	Part II. Other significant co	onditions	contributing t	o death b	ut not result	ang in un	e underryn	ig cadoc	givoiriii		1 _	Yes 2	✓ No	3	Probably 4 Unkno
P.O	ires the signe	od be												Nas an	24	b. Wer	e autopsy findings avai r to completion of cause
ş	v requ	ompleted								_				autopsy performe		deat	
Seco	he lav ate ha	Tage of								00 FI-	of Door	h (Chock	only one)	Yes 2	NO		163 2
<u> </u>	an:]	C S	25. Was case referred to in	edical	ospital:		0 4 55	(Output	ont 2	DOA	Other		ing Home	5 Re	sidence	6(Other:
Ž.	hysici this c		1 🗸 Yes 2 N				2 ✓ ER	b. Time			jury at Wo		28d. Desc		v injury oc	curred	
ع ا	After	unera	27. Manner of Death 1 Natural 5	Pending		e of Injury th, Day,Yea 4/28/2	ır)				Yes 2		unkno	רוגער			
	ttend death.	y the	2 Accident	Investigation	on 28e Pla	4/ 20/ 2	ry - At home	e, farm, s	00 am	ory, offic	e building,	, etc.	28f 1 oca	tion (Stre	et and N	umber o	or Rural Route Number orch Woods Apt
į	lor A after Dire	filled in by the tune	3 Suicide 6 X	determined	Specify	v) f	ound:	resid	ence				Savage	<u>, MD</u>			
	To the Hospital Addressing Physician: The law requires that the death certificate be extinin 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia. To the Funeral Director: According 1800 2 should be detached for use as the burish.	y fille		ing Physici						the time	date and	place, ar	nd due to the	e cause(s	s) and ma	anner as	stated.
	the Ho in 24 the Fu	pletel	(Check only one) 2 Medic	al Examiner	:On the basi	s of exam	ination and	or invest	ilgation, in	itty opin	1011, 4040.		at the time.				
	To t With	completel	29b. Signature and title of		and manner	A A				29c. Lice	ense numb	per		- 1	290. Date	signed	(Month, Day, 100)
	7		10/11) 1	de	(1/	/				Ο.	C.M.E.				April 29	, ZUU	
			30. Name and address of	person who	completed ca	ause of de	ath (Item 2	3a)			_14!	. MD (21201				
	1		Susan Hogan MI		stant Med	lical Ex	aminer	111 F	Penn St		aitimore	e, IVID 2					
	1	Sta	e 31. Date filed (Month, Day	Year)	0.7	Registrar	's Signature	A	port.								
	Reg	gistr		0 1 201	UI A	Section 1		-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** April 29, Suzanne Ford 2007 12:08p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5695 Linton Road Sykesville Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, JUL 30, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√□ F 028-52-9377 79 Director France Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exacts or mast be multiped at Plymouth 1 ☐ Yes 2 ▼ No Directo Massachusetts Hu11 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Hull Shore Drive 0.2045 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiens Important: If item 27 is marked other than "na any Injury or other traumatic event, Ita Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clotaire Bohain Georgette Berthelin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Timmons/daughter 5695 Linton Road Sykesville. MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) High Street Cemetery 5/3/2007 Hingham. MA 21. Signature of Funeral Service Licer 22. Name and Address of Facility Haight Funeral Home & Chapel.
P.O. Box 195 Sykesville, MD 21

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. 410-795-1400) Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) No. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed signed by the attending physician and doe detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 1 ☐ Yes P ☐ No 9 ☐ Unknown 4 Pregnant at time of death 5 ☐ Other (specify) 9. Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2, No 1 Tyes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy performed certificate 2.□ No 2[1 Yes To the Hospital or Attending Physician: neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital Other: 4 Nursing Home 5 Residence 1 Inpatient 2 1 Tes 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 💯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) icense number

Registrar

State

30. Name and address of p

Day, Year) 0 1 20

2007

Division of Vital Records. P.O. Box 68760

rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

07-03111

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Sheri Frankel 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Year 0739 hrs Madical Examiner April 23, 2007 Sheri Denise Frankel 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery 13310 Georgia Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country) Indiana 49 November 29. 1957 1 M 2x F 579-80-6241 Usual Residence of Decedent 10d. Inside City Limits any 10b County 10c. City, Town or Location 1 Yes 2 X No or 28a-f show items 23a or 28a-f sho Maryland Silver Spring Montgomery death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 13310 Georgia Avenue United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes Yes, Give Year Widowed 4 Divorced Specify: Yes 2 X No specify. White "natural". <u>چ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical MD 21215-0036 I and 2 should be filed within Health and Mental Hygiene. Homemaker Own Home 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) event, 1 Be William F. Brammeyer, Ingrid Münchberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Ingrid B. Callihan / Mother #1129 So., 5225 Pooks Hill Road, MD 20814 Bethesda, Baltimore, N
permit. Pages I and
Department of Healt!
Important: If item
injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) April 28, 1 X Burial 2 Cremation 3 Removal from State National Memorial Park Donation 5 Other Specify: 2007 Falls Church, Virginia 22. Name and Address of Facility Rolert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501 21. Sky ture of Funeral Service Licenses M01473 MI. Approximate Interval Part I. Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. 'Medical Death Cardiomegaly and biventricular dilatation Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED the attending physician ed for use as the burial ##252E,27,perME, g868, 6/28/07 TT requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Dav Year Fetal death Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown signed by the 1 be detached fi Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? 2 No 1 ✔ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other: ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 1 V Yes 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: XNatural Yes 2 Pendina the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 24, 2007 (J14 Name and address of person who completed cause death (It m 23a) Assistant medical Examiner Theodore M. King, Jr., MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, E State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AFRIL **Physician** εÍ, JOHN GALVIN FITZPATRICK, SR. 2007 26:20PMM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∏**M 2□F Days Hours 216-24-7292 Feb 12, 78 1929 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10b. County 1 XYes 2 No Director Marvland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once. ral", or items 23a Examiner must b 340 Broadmoor Road 21212 <u>USA</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Y Yes 2 No 52-If Yes, Give 52-14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 52-54 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Finance Director State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent dePaul Fitzpatrick Marie Anita O'Conor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Keene Fitzpatrick (Wife) 340 Broadmoor Road, Baltimore, Maryland 21212
Date of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Ch Cemetery 4/26/2007 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Homeland, Maryland 21. Signat Mot Fundral S. Nie Viol au 22 Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC. Martin D. Lawson Martin D. Lawson

6500 York Road, Baltimore, Maryland
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACUTE MYELOID LEUKEMIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, sealing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Y ear 4 □ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a. Was an autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 📉 No 1 Inpatient မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No filled in by the fr 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State

DHMH 17 Rev 1/2001

<u>JOGINDER</u>

29b. Signature and title of certifier

Pin.

2 -ells

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEHTA.

29c. License number

OSLER DRIVE TOWSON,

D41410

29d. Date signed (Month, Day, Year)

07-03159 Patricia Griffin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 13652

			- For State		, ,		Certific	cate of	Death					Reg. No				
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I∰##÷⊃ Exa			Patricia Gai	1 Gr	riffi	n							Month April 24,	2007			1753 h	IIS .
			a. Facility Name (if not institutio	n, give st	treet and n	umber)		4	b. City, Tow		ocation of	Death		4	c. County o	f Death	1	
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5-0036 led within 72 hours after death with the Maryland bygiene.	narked other than "natural", or items 23a or 25a-1 sno event, the Medical Examiner must be notified at once.	<u>a</u>	11. Marital Status 1 Never Married 2 M	larried		ecedent Eve Forces?		IS. Wa	es, specify (Cuban,	Mexican,	Puerto F	Rican, etc.)		White			
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21215-0036 buld be filed within 7 Mental Hygiene.	marked other than "natura c event, the Medical Examir	a	Joseph Ugiansl					10h Mailia	n Addross						City or Tow	n Stat	e, Zip Code)	
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Baltimore, permit. Pages 1 a Department of He	ry or	н	21 Signat f Funeral Service	e License	e)	1	11	22.1	Name and A	ddress	of Facilit	ler	ling	Asut	on Sc	lwa	Witz	ke
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Med			failure. List only one cause			peritor	eal he	morrha	00								1	Death
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter cleath.	certif ector,	Be	25. Was case referred to medic examiner?		ospital:	1	2 🗸 EI)A	Other	-	ng Home 5	Re	sidence 6	Oth	ner:	
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Division o the Hospital or Attending hin 24 hours after death.	To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be deta	Medical Certification:	29a. Certifier 1 Certifying	Physicia	an: To the	best of my	knowledge	, death occ	urred at the	time, d	ate and pl	ace, and	due to the	cause(s	and mann	er as s	tated.)
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F. ≥	5 5	₹	29b. Signature and title of cert						290	. Licens	se number			2	9d. Date sig	ned (#	Month, Day,\	/ear)
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0 0 K	L)	ļ	30. Name and address of pers	on who	completed	cause of de	ath (Item 2)	3a)										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 6:51 2007 GALINN HOWARD /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner SQUARE HOSTIAL RANKI BALTIMORE KOSET 6. Sex 1 M 2 □ F 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 217-58-7303 50 Director 05/24/1956 MD Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or : 54 OPEN GATE COURT 21236 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 Ño Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+)
5 + filed within Hygiene. Elementary/Secondary (0-12) 中 COMPTROLLER COMPASS GROUP is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be finance of the second se JULES GALINN ျှ FLORINE Pages 1 and 2 should GREENSPON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai ALBERT GALINN/ BROTHER 29 TURNMILL COURT, BALTIMORE, MD 21236 Baltimore, 20b. Place of Disposition (Name of ARCINGTON CHIZUK AMUNO CONGREGATION 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/29/2007 | BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cell Car CINOMA TASTAT Securitielly list occilies, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Division or Vital Records, P.O. 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 1□ Yes 2 1 No 1 ☐Yes 2 ☐ No Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKIN BALTIMORE, MD. 21237 SPUARE Dr. GANGALAM 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** HERBERT GOLDBERG APRIL 24 2007 6:45A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 217-80-2753 01/11/1955 Director MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits r 28a-f shov notified at 1 ☐ Yes 2 No **Funeral Director** MD BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or r must be r 3812 BYXBEE ROAD 21133 r than "natural", or items the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) NONE College (1-4or 5+) NONE NONE permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JOSEPH** ပ GOLDBERG **ESTHER** BREEDLOVE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELODEE YATES/ SISTER 3812 BYXBEE ROAD, RANDALLSTOWN, MD Baltimore, 20b. Place of Disposition (Name of MARY LAND VETERANS GARRISON FOREST 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/30/2007 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (H) weeks /Medical s a consequence of): Examiner Greeks if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day,

MAY 0

DHMH 17 Rev 1/2001

Registrar

6701

de

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BINC

32. Registrar's Signature

Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 30, 2007 Month AFRIL **Physician** ROBERT EDWARD GAEGLER 4:50A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Hours | Min. | August 14,1932 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XXM 2 F 74 Mary land 212-30-0851 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Instit if item 27 is marked other than "natural", or items 23a or 28a-f show mit; if item 27 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No Directo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8101 Bellona Avenue 21204 USA Funeral 12. Was Decedent Ever in U.S. Argued Forces? NAYSes 2□No Korea If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes XX No altimore, Maryland 21215-0036 White þ ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Joseph Gaegler Frances Bitzer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dtr-In-Law 2822 St Paul St Baltimore, Maryland 21218 Darlene Harenberg 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot i 🕍 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem Gar 5/3/07 Timonium Maryland Donation 5 ☐ Other (Specify) gnature of Funeral Set 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc **L**icense 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician RENAL FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending pl 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> ISCHEMIC CARDIOMYOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No certificate has b rector, page 2 sl 24a. Was an MULTI-INFARCT DEMENTIA autopsy performe 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0017695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. HELOL 7601 OSLER DRIVE TOWSON. MARYLAND 21204 ABDALLAH 31. Date filed (Month, Day, Year) 32. State MAY 01 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	•	partment of H ertificate of I			g. No.	7 13856		
	Physici	an	1. Decedent's Name (First, Middle, Last) Elizabeth Patterson Ma	artion Grava			2. Date of Deat Month April 27,		3. Time of Death 4PM M			
	/Medio Examin		4a. Facility Neme (If not institution, give s 4 Pickburn Court			4b. City, Town, or Cockeysv			4c. County of			
i di	Funeral Director			7. Age 7. Age 7	(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 H Hours M	in. 8. Date of Birth (Month, Day, August 29,	1935	9. Birthplace (State or Foreign Country) Maryland		
with the Maryland	he Maryland 8a-f show oliffed at	Director	10a. State 10b. County Maryland Baltimore									
	with the	Dire	4 Pickburn Court			10f. Zip Code	030	11	10g. Citizen of What Country? USA			
036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. erked other than "natural; or items 23s or 28s-f show atic event, the Medical Examinar must be rodified at	by Funeral	11. Marital Status 1 Never Married 2XX Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 200 N If Yes, Give Year or Dates:	ver in U.S. 1	3. Was Decedent of H If Yes, specify Cuba 1 Yes XX No		(Specify Yes or No- erto Rican, etc.)	14. Race	- American Indian, White, etc. White		
9500-6121	vithin 72 ho ne. han "natur a Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5-	(G	cedent's Usual Occup ve kind of work done on DO NOT use retired	during most of (d)	working	16b. Kind of Busi			
Maryland 21	d be filed wental Hygie ked other tice event, III	To Be Co	17. Father's Name (First, Middle, Last) William Martien	2	2 Realtor			Name (First, Middle, M Patterson				
Maryi	12 sh h and 7 is m traum	Ĕ	19a. Informant's Name/Relationship (Ty) William C Grove	_{ов, Print)} Husba		-		Rural Route Number,		tate, Zip Code)		
Baitimore,	ges 1 and of Healt if item 2 or other		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ R	emoval from State	20b. Place of Dis	sposition (Name of rematory or other place	ce)	Date	20c. Location - C	City or Town, State		
Ĕ	Pag ment ant:		*4 Donation 5 Other (Specify) 21. Finature of Funeral Servi & License		Churchvill	e Pres. Ch.				lle, Maryland		
g	permit. Departr Importu eny inji		James There	enken	akis	22. Name and Addie		Mitchell-wie k Road Balti		neral Home Inc yland 21212		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each lin Coronar	the death. Do not e. y Artery consequence of):		g, such as card	diac or respiratory arre	est,	Approximate Interval Between Onset and Death		
8/60,	certificate be executed nding physician and use as the burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to dimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):							
O. Box 6	death e atter	Physiclan/Med	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🗖 No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 1 □ Live birth 1 □ Pregnant at 1 □ Unknown	of delivery h Day Year							
ecords, P	law requires that the as been signed by th 2 should be detache	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 X							e contribute to the cause of death? No 3 Probably 4 Unknown		
	law renas bee	Completed	Asthma			·			autonsy prior to completion of cause of			
Vitai K	i ician: The la certificate has rector, page 2		Bipolar Disorder						!□No 1L	ath? ∐Yes 2 X ∷No		
	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 🗌 Inpatier	tient 3 DOA Oth	- 100	th (Check only one) ome XX Residence 6 Other (Specify)					
Nivision	ding h. After fune		27. Manner of Death 1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time Year) Injur		28d. Describe ho	28d. Describe how injury occurred				
	To the Hospital or Atten within 24 hours after deat To the Funeral Director; completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, . (Specify)	street, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Hospitat or 24 hours afte Funeral Dis etely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination	Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.								
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Mich		29c. Licens	2:	29d. Date signed (Month Day, Year)				
-			30. Name and add a person who co				e 204 T	owson MD 2	21204	/		
	Sta Registi		31. Date filed (Month, Day, Year)	32. Po gi s tra	r's Signature	hart 1						

DHMH 17 Rev 1/2001

07-03147 Daniel L Gordon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 13857 1- For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 24, 2007 1158 hrs **Medical Examiner** DANIEL LEE GORDON. SR. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Washington Parking Lot of 17772 Garland Groh Boulevard Hagerstown If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Director 164-46-3818 1 XM 2 F 51 Jan 16, 1956 Country) PA Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 10h County 1 X Yes 2 No or 28a-f show Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygien In "natural", or items 23a or 28a-f show
full protant: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other transmitic event, the Medical Essaniner must be notified at once. Halifax PA Perry County Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? P.O. Box 403 17032-0403 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes If Yes, Give Year Widowed 4 X Divorced Yes 2 X No specify: Specify: White ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth Leroy Gordon Emma Samantha Gordon ٩ 19a. Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 703, Ephrata, Erin H. Gordon (Daughter) PA 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 X Cremation 3 Removal from State Green Mount Crematory 4/27/2007 Baltimore, Maryland Donation 5 Other Specify: 21. Monature of Fundal Service Licensee ²² Milchell Wiederschaft HOME 6500 York Road, Baltimore, Mary Martin D. Dawson 21212 Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and 'Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Physician/Medical X UNPENDED AMENDED #1,23a,27,perME, g867, 5/25/07 TI Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Year Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? . death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Other₄ DOA Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 1 Yes 2 No 5 Pending 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 25, 2007 O.C.M.E. MIP COM 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

31. Date filed (Month, Day, Year)

32. Registrar's Signature

200

Ahmer Yasin Hussain

DHMH 17 Rev 1/2001

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Medhale Hygiene. Important: If itiem 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.			Yasin		in-	-Fath	er –	20h Place	e of Dispos				Ru	Date	I I	20c. Location	- City or	Town, State)
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Baltimore, permit. Pages I an Department of Hea Important: If ites injury or other tr.		2	1. Signature of F	uneral Serv	ice Licer	isee /			Ma	name and i	F/E	I Wes	st	_			M ä	212	115
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Box 68760, e death certificate be executed the attending physician and and for use as the burial - transit	Modion	2	UNPEND	ED	}[AMENDE	ΞD												
60, ate be		Me	F FEMALE:				es, outcome	of pregnar			2	Ectopi	c progr	ancv		23d. Date Month		y Day	Year
Box 687 death certifice the attending p	9	Physician	3b. Was deceded past 12 mon	ent pregnant hths?	in the		ve birth regnant at tim	ne of death		etal death other (Spe		Ectobi	ic progr	anoy					
OX (en i	200	1 Yes 2	No 9	Unknov	" =	nknown		5 (Mer (Spe	iony)					0.0			
that the de	i cuen	ᇍ	Part II. Other si	gnificant co	nditions	contributi	ng to death b	ut not resu	ulting in the	underlying	g cause	given in P	art 1.			oacco use co			
, P.O. res that the signed by		<u></u>												. 1	Yes	2 🗸 No			
ds, aquire een si	g pinous 7	Completed												24	a. Was a autops	sy	prior to		ings available of cause of
law r	us 7	힐												1	perfor Yes :	med? 2 ✔ No	death?	'es	2 No
tal Recian: The	, page	اق		. f	dinal					_	26.Plac	e of Death	n (Chec	k only on	e)				
tal cian:		m̃	25. Was case re examiner?			Hospital:	Inpatient	2 🗸 E	R/Outpatie		DOA	Other ₄	-	ing Home		Residence	6 Othe	er:	
f Vil	립니	의	1 ✓ Yes 27. Manner of D	2 No Death		28a.	Date of Injury Month, Day, Yea UND:		28b. Time o		28c. Inj	jury at Wo	rk?	28d. D	escribe h	now injury oc ged self	curred		
n of ading Pl	e funeral	<u></u>	1 Natural		Pending		UND: 26, 2007	" 1	FOUND: 1730 hrs		1	Yes 2	No						
Division of Vital Records, tal or Attending Physician: The law requirers after death.	by th	<u>icat</u>	2 Accider	•	Investig Could n	28e.	Place of Inju	ry - At hon	ne, farm, st	reet, factor	ry, office	building,	etc.	0.00	Town S	tate)			Number, Cit
Div ra after	lled ir	Certification:	3 ✓ Suicide 4 Homici	do	determi	ned (Spe	ecify) Sing	le Fami	ly							de Drive , C			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and					ng Phys	ician: To th	e best of my	knowledge	e, death oc	curred at th	ne time,	date and p	olace, a	nd due to	the caus me, date	se(s) and ma and place, a	nner as sta nd due to	ated. the cause(s	3)
o the of the	omple	Medical	one) 2			ner:On the b and man	asis of exami ner stated.	ination and	d/or investi			nse numbe				29d. Date	signed (M	lonth, Day,	Year)
OF SF	2	ž	29b. Signature	and title of o	ertifier	/				2		C.M.E.	51			April 27			
1			9	101	4	$V\chi$						J. 1VIL.							
2			30. Name and			no complete	d cause of de	eath (Item 2	23a) 111 P	enn Stre	eet. Ba	altimore	, MD :	21201					
0				logan MD			ledical Ex		e .										
Reg	Sta		31. Date filed (Month, Day,	rear)	חחק [Magaa.	, M.	A.	MES		_ ~							
DHMH 17 Rev				131 24 1 1		P			ORIGI										

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				State of Maryland / Department of Health and M	ental Hygi	ene, n n 7	10050		
				For State Registrar Certificate of Death		g. No.	13033		
		Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death		
	1	/Medic	al .	Kathleen W. Holland 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	April	26, 2007 4c. County of Death	02:10 A ^M		
		Examin	er	GREATER BALTIMORE MEDICAL CENTER TOWSON		BALTIMORE			
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)			
		Director		225-12-3752 1 M 241F 86 Yrs. Usual Residence of Decedent	July 10,	1920 Vir	ginia		
		yland Now		10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits		
~		e Mar	Director	Maryland Baltimore Timonium			1 ☐ Yes 2X No		
1		with th		10e. Street and Number 10f. Zip Code	10	g. Citizen of What Coul	ntry?		
0		ne 23	Funeral	12261 Roundwood Road 21093 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sperify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Americ			
9	9	or Iter	Fur	1 □ Never Married 2 □ Married 1 □ Yes 2 MX No 1 □ Yes 2 MX No Specify:	Hican, etc.)	Black, White,	etc.		
thlee	003	within 72 hours after death with the Maryland ane. than "natural", or Iteme 23a or 28a-1 ehow than Madical Examtier must be notified a	d by	3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	1 4	6b. Kind of Business/In			
7	15-	n "nat	piete	(Specify only highest grade completed) (Give kind of work done during most of works life. DO NOT use retired)		op. rand or buomosam	333.,		
20	212	giene giene er tha	Completed	12 n/a Homemaker		Own Ho	ome		
_	and	be file	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name					
0	ryla	hould d Mer marke matic	2	Benjamin Wyatt Walker Eva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Pura			nor Code)		
2	Mary	nd 2 salth an 27 ls		Susan M. Friedman/Daughter 14 Talbott Avenue, Tim					
0	ore,	es 1 a of Hei f Item r othe				20c. Location - City or T	own, State		
10	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be collified at ODGe.		4 Donation 5 Other (Specify) Metro Crematory 4/28	/07	Catonsville	e, MD		
工	Bal	Departiment Department		Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Hom 10 W. Padonia Road	e of Dul	aney Valley	Inc.		
				23a. Part1. Enter the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart fail fe. List only one cause on each line.	or respiratory arre	est,	Approximate Interval Between		
	4	Pnysician		Immediate Cau e (Fin disease or condition			Onset and Death		
	1	/Medical Examiner		Due to (or as a consequence of):					
			e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury					
		cuted	Examiner	that initiated events C.					
	,092	be exe ician ar burial-1		resulting in death) Last Due to (or as a consequence of):					
	687	ficate to physical ph	edicai	d					
	Box 68	h certii ending use a	In/M	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3□Ectopic pregnancy		23d. Date of deliv	•		
		e deat the att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Month	Day Year		
Ú.	P.O.	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	/ Ph)	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?		
	rds	quires nn sign uld be	ed by		1 □ Ye	es 2□No 3□Pro	bably 4 Minknown		
	Division of Vital Records,	2 50	Completed		24a. Was ar	y prior to co	opsy findings available ompletion of cause of		
	<u>=</u>		Con		perform	ned? death? 2 No 1 ☐ Yes	2 🗆 No		
	Vita	eician certifi irector	o Be	25. Was case referred to medical examiner? 1		e) ince 6 □Other (Spec	(6)		
	of	g Phye er this ieral di	-	27, Manner of Teath 28a. Date of Injury 28b. Time of 28c. Injury at Work?		w injury occurred			
	sion	r Attending P er death. irector: After t i by the funera	atio	2 Accident investigation M 1 Yes 2 No					
	Vi∨is	or Att after d Direct in by I	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	reet and Number or Rui n, State)	ral Houfe Number,		
ii	_	To the Hospital or Attending Physician: within 24 hours after death. **Q the Funeral Director: After this certific cumpletely filled in by the funeral director.		29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.	and due to the ca	ause(s) and manner as	stated.		
		the Ho	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.		ate and place, and due			
		2105	2	29b. Signature and little of certifier 29c. License number		1121010	7		
		á		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7	12010	(200		
		0		5 WEUTZER MY 12221 TULLAMORE NO 111	monle	um, mo	21010		
(3)		St Regist	ate rar	31. Date filed (Month, Day, Year) AND 1 2007 Registrar's Signature		/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mai	rylaria / i	Certificate of	Death	Re	eg. No.	J /	1306		
k T	Physicia	_	1. Decedent's Name (First, Middle, L Lawrence	Bernard	Ham	ilton		Date of Deat Month		/001	Time of Death		
	/Medic Examin	_	4a. Facility Name (If not institution, g Baltimore Washin		l Cente	er Glen B		4c. County of Death Anne Arunde1					
ħ.	Funeral Director		216-07-3751		(In yrs. last bi	Yrs. If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, April 1	Year)	9. Birthplace Country) MD •	(State or Foreig		
arvland	show dat	_	Usual Residence of Decedent 10a. State 10b. County						Inside City Limits				
at W	r 28a-f show	rectc	MD. Anne Ar	undel	Pasade	ena 10f. Zip Code		1	0g. Citizen of Wh	nat Country?	?		
with	23a or	I Di	1813 Poplar Rid	ge Rd.			122		U.S.A.				
1215-0036 within 72 hours after death with the Maryland	ours arrer deau rral", or Items 2 Examiner mu	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1XXYes 2 ☐ No If Yes, Give Year or Dates: ↓	0	13. Was Decedent of F If Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)		American I White, etc.			
21215-0036	"natural",	Completed	15. Decedent's (Specify only highest of	Education trade completed)	16a	a. Decedent's Usual Occup (Give kind of work done	nation during most of working	7	16b. Kind of Busi	ness/Indust	try		
21215-0	han "i	mple	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4or 5+)									
d 2	Hygie Hygie Ither t	ပ္ပို	17. Father's Name (First, Middle, La								estinghouse en Surname)		
<u>an</u>	lid be ked o ic eve	To Be	George W. Hamilton Elizabeth He							iderson			
ary	and M		19a. Informant's Name/Relationship		'	b. Mailing Address (Street					de)		
altimore, Mary	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany injury or other traumaite event, the Medical once.		Mary E. Shiplet,	daugnter		313 Poplar R				on - City or Town, State			
Baltimore, Maryland			20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3		1	of Disposition (Name of lery, crematory or other pla on Park	^(ce) 5/2/2			atonsville, Md.			
ltin	artmer ortant injury		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice		Loude		ess of Facility Lor	1					
Z &	Depa Impo any I		Manda Lemmer 8728 Liberty Rd., Randallstown, Md. 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
E	Chysician and Medical Examiner as the pnial-transit	Aedical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c. Due to (or as a d.	consequence	of non b	leeding			Or	nset and Death		
O. Box (the death certil y the attending iched for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗆 Fetal dea	th 3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date Mon	of delivery oth Da	ay Year		
ds, P	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	by	Part II. Other significant condition	s contributing to death bu	it not resulting	in the underlying cause gi	ven in Part I.	23e. Did to	es 2 No		cause of death ly 4 □Unkn		
Il Recol		Completed						24a. Was a autop perfor 1 Yes	sy pi rm <u>ed</u> ? de	rior to compl eath?	y findings availation of cause		
Vite	slclan certifi rector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 12 Inpatie	nt 2 🗆 EB/6	Outpatient 3 DOA Of	26. Place of Death		ne) lence 6 ⊟Othe	r (Specify)			
0	g Phy er this eral di	l Im.	27. Manner of Death	28a. Date of Injui	ry 28h	o. Time of linjury 28c. Injury			now injury occurre				
Division or Vital Records, P.O	I or Attendin after death. Director: Aft I in by the fun	Certification:	Natural 5 Pending investiga 3 Suicide 4 Homicide determin		ation (Street and Number or Rural Route Number, v or Town, State)								
_	e Hospital 24 hours e Funeral etely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examination	lge, death occurred at the and/or investigation, in my	time, date and place, a opinion, death occurre	and due to the ed at the time,	cause(s) and mai date and place, a	nner as state and due to th	ed. ne cause(s)		
	To the within To the comple	Me	29b. Signature and title of certifier		-	29c. Licer	ise number		29d. Date signed	(Month, Da	ay, Year)		
	/		Az Torr		m0	D4:	3977		Aparl	58	2005		
-	27		30. Name and address on erson w	ho completed cause of d	eath (Item 13a	a) (Type, Print)	Du. A.			10/-1			
	2	1	31, Date filed (Month, Day, Year)	32. Registra	ar's Signature	y wine,	vuen ou	HC.	MM- 5	1001,			
	St Regist	ate rar	MAY 0 1 20	n7	- J	1-3							

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			4 101	epartment of Health and M Certificate of Death	lental Hygien	400/ 10001
ı	Dhysisi	20	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month D	3. Time of Death
	Physicia /Medic		Peggy Ruth Hohman		April 26	, 2007 11:20 P. ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
			Futurecare Canton Harbor 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign
	Funeral Director		10M 20E	Months Days Hours Min.	Month, Day, Yea	r) Country)
	D D		Usual Residence of Decedent		ember 05 1	
	show	_	10a. State 10b. County 10c. City, Town Maryland Baltimore 1.0c.			10d. Inside City Limits
	Ba-f	Director	LOC	hearn		1 ☐ Yes 2X No
	hours after death with the Maryland turel', or ttems 23a or 28a-f show at Exacil, ar mast be multiad at		10e. Street and Number 3629 Lochearn Drive	10f. Zip Code		Citizen of What Country?
	ns 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	21207 13. Was Decedent of Hispanic Origin? (Spe		d States of America
۵	or Her		Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X☐XNo	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
200	rel', c	d by	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 🏋 No Specify:		Specify: Caucasian
7	72 h "netu	Completed	15. Decedent's Education 16a. [(Specify only highest grade completed) (Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)	ing 16b.	Kind of Business/Industry
9500-61212	filed within 72 Hygiena. Hyer than "nelsther than "nelsther than "nelsther than "nelsther than "nelsther than "nelsther than 11c.	дшо	Elementary/Secondary (0-12) College (1-4or 5+)	Home Maker		Own Home
	be filed within 72 hours after death with the Marylan tall Hygiena. dai Hygiena. dai Hygiena. dent, Its Marilos Exacilier mast be nutitied at a seent.	e Co	12 0 17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	en Surname)
Maryland	should be ad Mental markad o matic eve	To Be	Frank A. Ruth	Jeanett	e Gaule	
a <	should and Men marks umatic		19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Rura		or Town, State, Zip Code)
	as 1 and 2 should to of Health and Ment item 27 is markact rother traumatic e		Paul M. Hohman (Son)	37 Covington Street,	Baltimore	e, Maryland 21230
o O	of He of He fiten		20a. Method of Disposition 20b. Place of I	Disposition (Name of c, crematory or other place)	Date 20c.	Location - City or Town, State
altimore,	Pages ment of I lant: If it		`4 ☐Donation 5 ☐Other (Specify) Woodla	wn Cemetery 04/30	/07 Wood	llawn, Maryland 21207
ga	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Lori	ng Bvers]	Funeral Directors,Inc
	40240		23a. Part1. Enter the disease, or complications that caused the death. Do not	8728 Liberty Road	Randallet	
Ь			shock, or heart failure. List only one cause on each line.	i Salar as cardiac c	or respiratory arrest,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	mys lung DiTr	YFN	
P	Examiner		Due to (or as a consequence of	7		
		Jer	Sequentially list conditions, it any, leading to infimediate cause. Enter Underlying Cause (Disease or injury	fy:		
	cuted nd ransit	Examine	that initiated events			
Ď	e exe ian a urial-1		resulting in death) Last Due to (or as a consequence of	f): 		
8/60	cate be executed physician and the burial-transit	dicai	d	NU		
٥ ×	leath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			
ROX	atten for u	Physician/Me	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	15	23d. Date of delivery Month Day Year
o.	that the de led by the a detached	ysi	1 Yes 2 Unknown 9 Unknown	o a cities (opeony)		
J	res that igned b be deta	2	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	230 Did tobassa	use contribute to the cause of death?
ğ	m (2) (>		, ,	236. Did tobacci	
	an signal	ed by	Dinata			2 ☐ No Probably 4 ☐ Unknown
၀ ပ	law require as been sig 2 should b	pieted by	Dimata It By		1 ☐ Yes 24a. Was an	2 No Probably 4 Unknown
I Records,	Tha law requi ate has been s page 2 should	Completed by	Dimata 14 By		1 Tes	2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
		Be Completed by	25. Was case referred to medical examiner?	26. Place of Death	1 Yes 24a. Was an autopsy performed?	2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
Vital	thysicien: this certifica al director, p	To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outs	26. Place of Death patient 3 □ DOA Other: 4 tursing Ho	1 Yes 24a. Was an autopsy performed? 1 Yes 220 N (Check only one) me 5 Residence	2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes No 6 Other (Specify)
or Vital	Physicien: this certifica al director, p	To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death patient 3 DOA Other: 4 ursing Ho me of 28c. Injury at (jury Work?	1 Yes 24a. Was an autopsy performed? 1 Yes 220 (Check only one)	2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes No 6 Other (Specify)
or Vital	Physicien: this certifica al director, p	To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No	patient 3 DOA Other: 4 tursing Home of ury Mork? M 1 Yes 2 No	1 Yes 24a. Was an autopsy performed: 1 Yes 2 Yes	2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 10 Yes No 6 Other (Specify)
or Vital	Physicien: this certifica al director, p	To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No	patient 3 DOA Other: 4 tursing Home of ury Mork? M 1 Yes 2 No	1 Yes 24a. Was an autopsy performed: 1 Yes 2 Yes	2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes No 6 Other (Specify) ury occurred
or Vital	Physicien: this certifica al director, p	Certification: To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No	patient 3 DOA The of ury M 1 Yes 2 No me, street, factory, office	1 Yes 24a. Was an autopsy performed? 1 Yes 24a. Was an autopsy performed? 1 Yes 24b. Check only one) 25d. Residence 28d. Describe how in autopsy performed? 28f. Location (Street City or Town, Sta	2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes No 6 Other (Specify) and Number or Rural Route Number, (s) and manner as stated.
or Vital	Physicien: this certifica al director, p	Certification: To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No	patient 3 DOA The of ury M 1 Yes 2 No me, street, factory, office	1 Yes 24a. Was an autopsy performed? 1 Yes 24a. Was an autopsy performed? 1 Yes 24b. Check only one) 25d. Residence 28d. Describe how in autopsy performed? 28f. Location (Street City or Town, Sta	2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes No 6 Other (Specify) and Number or Rural Route Number, (s) and manner as stated.
or vital	Attending Physicien: or death. ector: After this certifice by the funeral director, p	To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No	patient 3 DOA The of ury M 1 Yes 2 No me, street, factory, office	1 Yes 24a. Was an autopsy performed: 1 Yes 24a. Was an autopsy on the control of the control of the cause o	2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) and Number or Rural Route Number, (s) and manner as stated.
or vital	Physicien: this certifica al director, p	Certification: To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death patient 3 DOA Ther: Work? M 28c. Injury at Work? M 1 Yes 2 No There, and the time, date and place, for investigation, in my opinion, death occurred.	1 Yes 24a. Was an autopsy performed: 1 Yes 24a. Was an autopsy on the control of the control of the cause o	2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 10 Yes No 6 Other (Specify) ury occurred and Number or Rural Route Number, ite) (s) and manner as stated. Indiplace, and due to the cause(s)
or vital	To the Hospitel or Attending Physicien: within 24 hours after death To the Funerel Director: After this certification occupietely filled in by the funeral director;	Certification: To Be Completed	25. Was case referred to medical examiner? 1	Datient 3 DOA Other: 4 Thursing Home of Jury M 1 Yes 2 No me of Jury M 1 Yes 2 No m, street, factory, office death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, and for investigation at the time, date and place, for investigation at the time, date and place, for investigation at the time, date and place, for investigation at the time, date and place, for investigation at the time, date and place, for investigation at the time, date and place, for investigation at the time, date and place, for investigation at the time, date and place, for inves	1 Yes 24a. Was an autopsy operformed? 1 Yes 2 On (Check only one) me 5 Residence 28d. Describe how in City or Town, State and due to the cause ed at the time, date a	2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 10 Yes No 6 Other (Specify) ury occurred and Number or Rural Route Number, ite) (s) and manner as stated. Indiplace, and due to the cause(s) late signed (Month, Day, Year)
or vital	To the Hospitel or Attending Physicien: within 24 hours after death To the Funerel Director: After this certification occupietely filled in by the funeral director;	Medical Certification: To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No	Datient 3 DOA Other: 4 Thursing Home of Jury M 1 Yes 2 No me of Jury M 1 Yes 2 No m, street, factory, office death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, in my opinion, death occurred at the time, date and place, for investigation, and for investigation at the time, date and place, for investigation at the time, date and place, for investigation at the time, date and place, for investigation at the time, date and place, for investigation at the time, date and place, for investigation at the time, date and place, for investigation at the time, date and place, for investigation at the time, date and place, for inves	1 Yes 24a. Was an autopsy operformed? 1 Yes 2 On (Check only one) me 5 Residence 28d. Describe how in City or Town, State and due to the cause ed at the time, date a	2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 10 Yes No 6 Other (Specify) ury occurred and Number or Rural Route Number, ite) (s) and manner as stated. Indiplace, and due to the cause(s) late signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			Registrar		Certifica	ate of	Death					eg. No.				
Med	Physici lical Exam			e Timothy H						Ar Ar	ate of Deat lonth oril 25, 2	Day 007	Year		3. Time of Death 2323 hrs	
			4a. Facility Name (if not institution, University Hospital	give street and number)		ľ	tb. City, To Baltimo		ocation of De	eath		4c. C	County of D	Death /A		
	Funeral Director			7. Ag	e (In yrs. last birth	nday) Yrs	If Under Months	1 Year Days	If Under 24 Hours	Min	Date of Bir	,	D/YYYY) 9	9. Birthr oreign	olace (State or htry) Mary 1a	and
	ly .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town						, , ,				Od. Inside City L	
	nd show any ice.	'n	Maryland Howar	d			iotts	vill	e		1 Yes 2 X					_
	ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 1366 Driver Ro	ad			10f. Zip C	ode 2110	/1		1	_	n of What JSA	Countr	y?	
	with the ns 23a o be notifi		11. Marital Status	12. Was Decedent			s Decedent	of Hisp	anic Origin?				4. Race - A		ın Indian, Black,	
	15-0036 filed within 72 hours after death with the Maryland I Hygiers d other than "matural", or items 23a or 28a-f she d other than "matural", or items tha notified at once t, the Medical Examiner must be notified at once	by Funeral		1 Yes 2 If Yes, Give Year or Dates:	X No	1	Yes 2	No.					,	Whi		
	72 hours a "natural Exam	eted	15. Decedent's Education (Specif Elementary/Secondary (0-12)	y only highest grade cor College (1-4 or	5+)	during m	ost of worki	ng life. [n (Give kind OO NOT use		done	16b. Kin	id of Busir	ness/Inc	dustry	
	5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, L	4	Po	lic	e Off:		3.Mother's N	amo /Fire	t Middle I			orc	ement	
	21215-0036 unld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	John Richard	Hoffman					Regi	ina H	Helen	Sch1	Leich			
	MD 21 d 2 should lth and Me n 27 is ma	7	19a. Informant's Name/Relationshi John Richard Ho						and Number oad Ma							7
	re, s l an f Hea If iter		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Spe		ate St Alp	ory or of	her place)		· ·	Da	te 2007		odst		own, State	
	Baltimo permit. Page Department o Important: injury or oth		21. Signature of Funeral Service Li			22. N	lame and A	ddress of une	of Facility ral Ho	ome 8	& Cha	pel,	P.A.			
	Physician		23a. Part I. Enter the disease, or confailure. List only one cause of	omplications that caused	the death. Do no	it enter t	he mode of	dying, s	5 Syke	ac or resp	oiratorý arr	est, shock	784 k, or heart	(410	—795—14∩∩ Approximate Int Between Onset	erval
	'Medical :aminer	i	Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a cons						_					Death	
		-	Sequentially list conditions, if any, leading to immediate	b	equence of):	_								-		
J	ed nsit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):											
V	760, icate be executed physician and the burial - transi	dical	UNPENDED	dAMENDED												
	as as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkn	4 Pregnant at	me of pregnancy 2 t time of death 5		etal death	3 [5y)	Ectopic pre	egnancy			Date of de nonth	elivery Da	y Year	
	P.O. Box 68 s that the death certigned by the attending edetached for use a		Part II. Other significant conditio	9 Unknown	h but not resulting	g in the u	underlying o	ause giv	ven in Part I.		23e. Did to	obacco us	se contribu	ute to th	e cause of death	1?
	S, P.O. uires that the signed by the detacle	ed by)	_						_			No 3			
	ision of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death cer redeal. After this certificate has been signed by the attendi by the funeral director, page 2 should be detached for use	Completed by	[- 1	24a. Was autor perfo	osy rmed?	prid dea	or to co ath?	ppsy findings ava mpletion of caus	e of
	tal Rection: The certificate ector, page		25. Was case referred to medical		 .		20	: Dingo	of Death (Ch	eck only	1 Yes	2 No	1	Yes	2 N	:0
	ital sician is cert irecto	BB	examiner?	Hospital: 1 ✓ Inpatio	ent 2 FR/Q	utpatient		10	Whor:	ursing Ho		Residence	ce 6	Other:		
	of Vi ing Physi After this uneral dir	n: To	1 Ves 2 No 27. Manner of Death	28a. Date of Inju (Month, Day) Apr 25, 2007	ury 28b.	Time of I			at Work?	28d	. Describe lestrian	how injury	y occurred	1	ser	
	Division tal or Attendin safter death. al Director: Aled in by the fi	catio	1 Natural 5 Pendir 2 ✓ Accident Investi	gation 28e Place of Ir	0129			1 ✓ Ye		,					al Route Number	City
	Division of Vital Soptal or Attending Physician: hours after death. neral Director: After this certif y filled in by the funeral director,	Certification:	3 Suicide 6 Could determ	not be	paved Road	, 0					or Town, S	State)			Wheaton, Md.	,
	Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of miner:On the basis of exa and manner stated	ny knowledge, dea mination and/or i	ath occur nvestiga	rred at the t tion, in my o	ime, dat opinion,	e and place, death occurr	and due red at the	to the caus time, date	se(s) and and place	manner a	s stated to the	d. cause(s)	
	F % F S	Me	29b. Signature and title of certifier	-4				License				29d. Da	ate signed	(Mont	h, Day, Year)	
			Cabelle	TUL	double (livery 22)			O.C.N	1.E.			April	26, 200	7		
	15		30. Name and address of person w Zabiullah Ali, M.D. A	ho completed cause of a ssistant Medical E		11 Per	n Street	, Baltir	nore, MD	21201						
	S Regis	tate trar	32 A 1 / 1 / 7 /	32 Registra	ar's Signature	don	الرجيع									
		_	3967 9 3	And April 19 and A		N.										

			State of Maryland / Dep 1- State Amend #19a Per INF G867 5/15/@7	partment of Health and N ert ific ate of Death	lental Hygier Reg. ۱	0007 10000
·	Physici		1. Decedent's Name (First, Middle, Last) Leonard Vincent Hagen		2. Date of Death	Day 2007 3. Time of Death 5:00 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 603 West Drive	4b. City, Town, or Location of Death Glen Burnie	1	4c. County of Death Anne Arunde1
No.	Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 3-31-1921	9. Birthplace (State or Foreign Country) MD
	aryland show ed at	٥٢	Usual Residence of Decedent			10d. Inside City Limits 1
	with the M a or 28a-f be notifie	Director	10e. Street and Number 603 West Drive	10f. Zip Code 21061	10g. (Citizen of What Country? USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>	by Funeral		I. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
Maryland 21215-0036	d within 72 hou giene. ir than "natura the Medical E	Completed	(Specify only highest grade completed) (Gillife Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of work DO NOT use retired) hographer	ing	Kind of Business/Industry Canning
land	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) John P. Hagen		B. Kenny	
	ind 2 shou aith and N 27 Is mai er traumai	0.00	ratificia C. Brager/neice	iling Address <i>(Street and Number or Rui</i> Black Rock Harbou		
Baltimore,	Pages 1 a nent of Her nt: If item iry or othe			ematory or other place)	.	Location - City or Town, State en Burnie MD
Balti	permit. Departrr Importa any Inju		21. Signature ral Service Licensee M01364	22. Name and Address of Facility Si l Second Ave SW Glo	ngleton Fu en Burnie	neral Home P.A. MD 21061
Y Y	Physician /Medical Examiner	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nter the mode of dying, such as cardiac desease of A Corrcenorua		Approximate Interval Between Onset and Death
P.O. Box 68760,	he death certificate be executed the attending physician and shed for use as the burial-transit	Physician/Medical Exa	Due to (or as a consequence of): d	□Ectopic pregnancy □ Other <i>(specify)</i> _		23d. Date of delivery Month Day Year
Division or Vital Records, P.	The law requires that the death certificate has been signed by the attending I sage 2 should be detached for use as	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the Chrome Renal formulae		1 Yes 24a. Was an autopsy performed	20 use contribute to the cause of death? 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 26 No
Vital	sician : The law s certificate has t lirector, page 2 s	Be	25. Was case referred to medical examiner?	Other:	1 Yes 2 A	
sion or	ilng Phy After this funeral d	ation: To	27. Manner of Death Takhatural 5 Pending 2 Accident investigation 2 Saa. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	ome 5 Residence 28d. Describe how in	6 ☐ Other (Specify) njury occurred
Divis	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)		City or Town, St	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in I	Medical	29a. Certifier (Check only one) 1★Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.			
	To t To t	M	29b. Signature and title of certifier	29c. License number 51596	29d.	Date signed (Month, Day, Year) Poul 27th 2007
	10		30. Name and address of person who completed cause of death (Item 23a) (Typ K. Ambalavanar 7845 Daku	e, Print) your Road, 103	Glan Bu	pril 27th 2007 rnie, ND 21061
	Sta Registi		31. Date filed (Month, Day, Year) 2007 39 Registrar's Signature	never		

7-03178 inda Carol Has	pert	Please Type or Print in Black Indelible Ink. Ensure Al State of Maryland / Department of Health and Mo		Legibl	45	· · · · · · · · · · · · · · · · · · ·			
		1- For State Certificate of Death		Reg. No	200	/ 1386			
Physici Medical Exami	an/	1. Decedent's Name (First, Middle,Last) LINDA C. HASPERT	2. Date of Month	Day	Year	3. Time of Death 1730 hrs			
vicultai Exami	ilei	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Locati		5, 2007	c. County of Death				
		339 Bar Harbor Drive Pasadena			Anne Arundel				
Funeral Director			lours Min.	,	#/DD/YYYY) 9. Bir Foreig -1952 Co	thplace (State or on West ^{untry)} Virginia			
nd show any ce.	_	10a. State 10b. County 10c. City, Town or Location Pasadena				10d. Inside City Limits 1 Yes 2 No			
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 339 Bar Harbor Drive 10f. Zip Code 21122		10g. C	U.S.A.	ntry?			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Departmet of Health and Mental Hygiene. Importment: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medic il Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 1 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Specific Control of No. Spec	dcan, Puerto Rican, etc.		14. Race - Amer White, etc.	ican Indian, Black,			
16 n 72 hours af an "natural' ie el Examin	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Security Special	Give kind of work done NOT use retired)		. Kind of Business/	c ^			
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. In 27 is marked other than numatic event, the Medica	ادہ	17. Father's Name (First, Middle, Last) 18.Mo	other's Name (First, Mid Mildred		en Surname)	riedde			
s, MD 212 and 2 should be lealth and Ments tem 27 is mark traumatic even	To B	19a. Informant's Name/Relationship (Type, Print) Michael W. Williams (Son) 19b. Mailing Address (Street and 316 Highland Dri							
nore, Nages I and ages I and of Health it: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Bayview Crematory	y. Date 04-27-07		Location - City or	Town, State Maryland			
Baltimore, permit. Pages 1 an Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of the rail Service Licensee ACCULTY FOLYT 3204 Mountain	niak Funera n Road, Pas	<u> </u>	•				
Physician /Medical		236. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line.				Approximate Interval Between Onset and			
caminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):				Death			
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated							
nd uted		events resulting in death) Last Due to (or as a consequence of): d.							
ficate be execute physician and the burial - tran	dica	UNPENDED AMENDED							
Ox 68 eath certil	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ec 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ctopic pregnancy	_ 2	23d. Date of deliver Month	y Day Year			
s, P.O. B ires that the d signed by the	d by Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Chronic alcohol use; Obesity		_		the causa of death?			
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rafter death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed by]_	Was an autopsy performed Yes 2	prior to death?	utopsy findings available completion of cause of			
Vital Rec ysician: The l his certificate l director, page	ادها		eath (Check only one)						
of Vit Physic er this e	To B	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at V			dence 6 Othe	er: Scene			
Vision of or Attending Phaser death. Director: After in by the funeral	tion	1 Natural 5 Pending (Month, Day, Yeer)			,,,,,				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Nor Town, State)							
Div To the Hospital o within 24 hours af To the Funeral D		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date an (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deat							
To To Y	Medical	29b. Signature and title of certifier 29c. License num			d. Date signed (Me				
		(and Hallar o.c.m.e.		A	pril 26, 2007				
5		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201						
S Regis	tate trar	31. Date filed (Month, Pay Year) 2007 32. Registrar's Signature	2 (20)						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** April 26, 2007 8:45 A Mildred Marie Ham /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Havre de Grace Harford Harford Memorial Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 20 F Director 60 Jan. 19, 1947 Virginia 213-94-9123 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 28 No Directo Harford Maryland Churchville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 the Mudical Exerniner count be "naturel", or itame 23a 127 Hopewell Road 21028 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 25 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 le marked other then Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Marie Matthews Robert Oscar Brown Sr. ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 127 Hopewell Road, Churchville, Maryland 21028 Herbert/R. Ham Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition At Pages 1 sement of F serient: If it 1 Durial 2 ☐ Crematio 4 Dorlation 5 □ Other 4-30-07 Pel Air, Maryland Bel Air Memorial Gdn 21 Sonature & An Name and Address of Facility Home, P.A. Departition Depart 1317 Cokesbury Road, Abingdon, Maryland 21009 3a. Part1. Enter the diseas shock, or heart failure. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ire. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** intre cerebral 6 Ceedin disease or condition resulting in death) /Medical Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

death. al or Attendi s efter death. à within 24 hours of To the Funerel I

> State Registrar

Medical

30. Na e an oddres of person who completed cause of death (Item 23a) (Type, Print) Andrew 16 Aberdeen Plaza, Aberdeen MD 4001 Mrowiec

come

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

047804

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

04/26/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 26,2007 4 : 014P AFRIL Betty Lou Houck /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Saint Joseph Medical Center Hours Min. B. Date of Birth (Month, Bay, Year) If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days Months 1 ☐ M 2 ☐ ¥ North Carolina 70 244-06-0039 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show t be notified at 1 ☐ Yes 2X No Director Maryland | Harford Aberdeen 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number death with USA 21001 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ratural" or items 23a any Injury or other traumatic event, the Medical Examiner must! 1542 Perryman Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo 3altimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Family Caregiver 11 d 2 should be filed with and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Enice Burkett Albert Byard Houck ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 103 Bluebill Court, Harve de Grace, MD 21078 Jeanne Baker / Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ 4 □ por ation 5 □ other (Specify 3 Demoval from State Zion U.M. Chr. Cem 5-1-07 Bel Air, Maryland ²² Name and Address of Facility Home, P.A. MCComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 21. Sig atu e of Funer Sen Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, F Immediate Cause (Final disease or condition CHRONIC OBSTRUCTIVE PULMINARY DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has b irector, page 2 sl autopsy performed 2 No 1 ☐ Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2X No 1 Inpatient 2 KER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After Injury (Month, Day Year) 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident death Director: 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide on 24 hours.

the Funeral Directory filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion death. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Attouding Phy

Registrar DHMH 17 Rev 1/2001

State

XIAO

31. Date filed (Month, Day, Year)

ZHOU M. D

0 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ORIGINAL

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Physician /Medica Examine

Funeral

	1 - For State Registrar	State of Maryl	and / Depa		lealth and	Mental Hy	giene Reg. No. 20	e.)7 3867		
an al	Decedent's Name (First, Middle, Las JOANNA TENNAN	T HOWE		4b. City, Town, o	at eaction of Dog	2. Date of De Month APRII	Day Ye			
er	4a. Facility Name (If not institution, give street and number) GILCHRIST 5. Social Security Number 220-40-8475 1							MORE Birthplace (State or Foreign Country) MARYLAND		
ctor	Usual Residence of Decedent 10a. State 10b. County MD	100.	. City, Town or Lo					10d. Inside City Limits 1 □ M es 2 □ No		
al Dire	1307 NORTHVIEW	ROAD		10f. Zip Code 21218	3		10g. Citizen of Wha			
Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 X No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No erto Rican, etc.)	Black, \	American Indian, White, etc. WHITE		
ompleted	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire CRETARY	eation during most of w d)	orking	16b. Kind of Busin	•		
To Be C	17. Father's Name (First, Middle, Last) JOHN TENNANT				MARY	MARGARI	Maiden Surname) ET MULLE	<u> </u>		
		stepdaught	1	18 PINE			FIMORE,	MD 21212		
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State /)	ULANEY	watory or other pla VALLEY	5/1	/2007		M, MARYLAND		
	21. Signature of Funeral Service Licen	ona4			ORK RO	AD MONE	KTON, MD	& SONS CO. 21111		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):									
ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unseltyfling Cause (Disease or injury that initiated events resulting in death) Last									
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Complete						1□ Yes	psy prio ormed? dea 2 No 1 □	re autopsy findings available or to completion of cause of th? Yes 2 \Box		
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lical Cer	29a. Certifier 1 Certifying Ph	ysician: To the best of my	knowledge, deat	h occurred at the ti	me, date and pla	ce, and due to the	cause(s) and mann	er as stated. d due to the cause(s)		
Med	29b. Signature and title of certifier	and manner stated.	7, m	29c. Licens			29d. Date signed (A	-		
te	30. Name and address of person who and address of person who are also address of person who a	completed cause of death completed cause of de	(Item 23a) (Type,	Print) Carles J	7. Bal	to and	2:20	15		
ar	MAY 1 - 2007	Statem 15	fresh.	<i>f</i>						

State Registrar

Discontinuation Name (First Andrea, Last) Proceedings Proceedings Proceded Pro		1	For State Registrar			Ce	rtificate	e of L	Death			Reg. No	UU /	1001
Technology Tec	ician										Month	Day	Yeer	
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Secul Security Number (ASS Security Number (ASS Security Number (niner				mber)					or Death		2.5	,	
Too Server and Number 2 100 County 100 College (14-or 5-) 100 Col					7. Age (In vrs.	last birthday)				24 Hrs.	8. Date of I	Birth		
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Mound U. 903MM D0047330 April 30, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			(Check only 2 Medical E	xeminer: On the b	asis of examina	wledge, deat ition and/or in	h occurred a vestigation,	at the tim in my op	e, date an inion, dea	nd place, ath occur	and due to the	ne cause(s) e, date and	and manner a I place, and du	as stated. ue to the cause(s)
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** MILDRED HUMMEL 9:34 APRIL 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WESTMINSTER CARROLL 3227 OLD TANEYTOWN Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 □ M 2√2 F 86 11,1920 MARYLAND **Director** 218-18-9914 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b County 28a-f show notified at 1 ☐ Yes 2 X No Director CARROLL WESTMINSTER MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a or the Medical Examiner must be 21158 USA 3227 OLD TANEYTOWN RD. death v Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married or l Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE ģ 3 ☑ Widowed 4 ☐ Divorced 'natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) HOME MAKER HOUSEWIFE 12 marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be PACKWOOD DAISY BRENNAN CHARLES 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 1 5 8 19a. Informant's Name/Relationship (Type. Print) VICTORIA L. BRILL -DAUGHTER 3227 OLD TANEYTOWN RD., WESTMINSTER, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State COUNTY CREMATION 4/30/07 SYKESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME, ignatu Service Licensee 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Coronson /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or I.ijury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trail Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IE EEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) page 2 should be detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Seati Shock 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No LALLUL 24a. Was an 1☐ Yes in by the funeral director, 26. Place of Death Check onl one Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled 24 hours a 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funel 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4.30.07

Registrar

State

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2483

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

TATE

Or.

2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 24 2007 4:15 PM April Richard Campbell Howard 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Towson Gilchrist Center 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1X M 2□ F 218-05-7540 88 August 7,1918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2XX No Baltimore Maryland | Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 United States 8029 Highpoint Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Maritai Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🛣 No Specify. Specify: white 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Company electrician 9 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last Catherine Mary Medinger William J. Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, MD 21234 8029 Highpoint Rd. Emily Howard/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 □Removal from State Dulaney Valley Mem Gar. Apr. 28,2007 4 □ Donation 5 □ Other (Specify) Timonium, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home,
6500 York Rd. Baltimore, MD 2 21. Signature of Funeral Service Licenses John O. Mitchel Approximate Interval Between Onset and Death 23a Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) b. deval reex Due to (or as a consequence of): Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnar/ Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 2☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Partient fell 27. Manner of Death 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 Natural in her iroun 3:30 PM 1 ☐ Yes 2 ☑ No April 14,2007 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) \$101 Belling three 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Arden Courts Assisted Loving Townson, mo 21204 4 Homicide

that the death certificate be executed and P.O. Box 68760. physician attending signed by the a d be detached f Records, certificate has Division or Vital this e Hospital or Attending P 24 hours after death. e Funeral Director: After t After 1

Physician

/Medical

Examiner

Director

Funeral

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Certification:

Medical

29a. Certifier

Saltimore, Maryland 21215-0036

To the Hospital within 24 hours at To the Funeral E

State Registrar A. R.le.

29b. Signature and title of certifier

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and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 11,1 25,2007

Towson, mo 21207

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charle St. failte Mel

31. Date filed (Month, Day, Year) MAY 0

Registrar's Signature

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	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ncation				10d. Inside City Limits
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	or 285	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cour	ntry?
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Registrar DHMH 17 Rev 1/2001

State

6701 32. Registrar's Signature Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

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			•	State of Maryla	ınd / Depa		lealth and l	Mental Hyg	_	13873
	Physicia /Medic	al	Decedent's Name (First, Middle, Last) Frieda May Hopkins Aa. Fecility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Deat	2. Date of Deat Month April	Day Year 27 2007	3. Time of Death 2:15 A. M
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036	De filed within 72 hours after death with the Maryland nial Hygiene. ad other then "naturel", or items 23e or 28a-f show event, the Madical Extrainer must be notified at	Completed by Funeral Director		. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	ŀ	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🎇 No	ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh:	
Maryland 21215-0036	within 72 ho jiene. rthen "natur the Medical j	ompleted	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo t)	rking	16b. Kind of Business/Ir	ndustry
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<i>')</i>	Sta Regist		RoBert L Berte; 31. Date filed (Month, Day, Year)	32. Projetrar's Si	8 Ba	ih ST	Balto,	My 2	1224	

Donald F. Haskell, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			1018 N. Charles Stree			Baltimore						n	ı/a		
Funera Directo			5. Social Security Number 220–62–4092	6. Sex	7. Age (In yrs.	-	If Under	1 Year Days	if Under Hours	24Hrs. Min.	8. Date of Bir 12/12/		Forei	gn	State or ew York
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executed an and			events resulting in death) Last	Due to (or as a	a consequence	of):		-							
be be	urial -	dical	X UNPENDED	AMENDED	b,27, per	ME, g868,	6/16/0)7 TT	1						
Ox 6876(ath certificate attending phys	use as the b	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes,	outcome of pre	gnancy 2 Fe	etal death ther (Specif)	3	Ectopic p	pregnan	су	23d. Dat Mon	te of delive th	ry Day	Year
Box he death o	ed	hysi		nown g Unkn							Top Divi	Щ_			
ires that the signed by	e deta	ρ	Part II. Other significant condit	ions contributing t	o death but not	resulting in the	underlying &	ause giv	en in Part			obacco use o s 2 No			v Unknown
cords law requ	2 should	Completed									24a. Was autop perfo	rmed?		completi	ndings available on of cause of
tal Rection: The certificate	ţ	Be C	25. Was case referred to medica examiner?				26.		of Death (C	Check or					
of Vital ng Physician Viter this certi	ral dir	ျ	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2	ER/Outpatient		`	at Work?		Home 5	Residence		er: Scene	
on of ending Pl ath. or: After	the func		1 X Natural 5 Pend	(Monti ling	h, Day,Year)				s 2 h						
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director:	filled in by	Certification:	3 Suicide 6 Coul	d not be mined (Specify)		home, farm, stre	et, factory, o	ffice bui	ilding, etc.	2	28f. Location (or Town, S		umber or R	tural Rout	e Number, City
he Hosp in 24 hou lee Fune			20a Certifier	nysician: To the be											(s)
Fo the within 2	сош	Medical	29b. Signature and title of certifie	and manner:	stated.				number		, aato	29d. Date			
Bi			Theodor 1	1,16	& JM,	mo,	(D.C.M	l.E.			April 24			
2000		Ī	30. Name and address of person Theodore M. King, Jr.		of death (Itel ant Medical		111 Pen	n Stre	et, Balt	imore	, MD 2120	1			
	Sta	ate	31. Date filed (Morte Pay, Yor)	2007 32.	egistrar's Signa	ture	-							-	

			1- For State of Maryland / Departm	ment of Health and Mo		ene No 2007	13875
9	Physic /Medi				2. Date of Death Month April	Day Year 24. 2007	3. Time of Death 6:30 A. M
	Exami		4 = 100 44	City, Town, or Location of Death TOWSON	APLII	4c. County of Deeth Baltimon	
40	Funeral Director			nths Days Hours Min.	8. Date of Birth (Month, Day, Ye June 29,		place (State or Foreign ntry) 11and
	Maryland of show	tor	10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 3a or 28e	al Director	10e. Street and Number 10 635 Tunbridge Road	of. Zip Code 21212	10g.	Citizen of What Cou	ntry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Hems 23a or 28e-f show any injury or other treumatic event, the Medical Evartiest must be notified at 2008.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No II Yes, Give Year or Dates:	Z1Z1Z Decedent of Hispanic Origin? (Spec, specify Cuban, Mexican, Puerto R fes 2 X No Specify:	ify Yes or No- lican, etc.)	U.S.A. 14. Race - Ameri Black, White, Specify: Whi	etc.
21215-0036	od within 72 h giene. er then "netu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 years	Usual Occupation of work done during most of working OT use retired) Secretary	g 16b	Church	
Maryland	should be filed nd Mental Hygi marked other umatic event, I	To Be (William Eckstein	18. Mother's Name (den Sumame) Ba11	
	s 1 and 2 si f Health an item 27 is r other treur		John J. Hinzmann (husband) 635 Tunk 20a Method of Disposition 20b. Place of Disposition	bridge Road Bal	timore, 1		21212
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 X Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) St. Mary of the	orotherplace) Assumption Ch. Cem.	4-28-07	Baltimore	. Maryland
8	88188		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	ne and Address of Facility Chell—Wiedefeld O York Rd. Bal mode of dying, such as cardiac or i	timore.	MD 21212	Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence by):	e			Interval Between Onset and Death
	Examiner	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		· · · · · · · · · · · · · · · · · · ·		4Dup
58760,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	edical Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of): d.	ys phagia			FDays.
.O. Box	at the death certifi by the attending rached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	oic pregnancy r (specify)		23d. Date of delive Month	ny Day Year
Records, P.	w requires that been signed the should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.		o use contribute to th	e cause of death?
		Completed	algheimens Dement	lia	24a. Was an autopsy performed? 1 ☐ Yes 2 €	prior to con death?	osy findings available npletion of cause of
VItal	ysician; is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2000 Hospital: Minimizer 2 SP/Output 2	26. Place of Death (C			
lon or	ا جا ا	⊢ ⊦	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death	TOOK TO Nursing Home	5 Residence	6 ☐Other (Specify jury occurred)
DIVISION	itel or Atterns after de rel Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, face building, etc. (Specify)		City or Town, Sta		
	the Hosp hin 24 hou the Fune npletely fii	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurr (Check only one) Certifying Physician: To the best of my knowledge, death occurr (Check only one) Medical Exeminer: On the basis of examination and/or investigat and manner stated.	tion, in my opinion, death occurred	I due to the cause(at the time, date a	(s) and manner as stand due to	ated. the cause(s)
	T Will		Decroma MD	29c. License number		Vate signed (Month, D	
6)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID BOTTSMA 7505 OSCER DM	C # 510 TO	wsin r	וב מא	204
	Stat Registra	9	31. Date filed (Month, Day, Year) MAY 0 1 2007	85			

Funeral

Director

"natural", or Items 23a or 28a-f

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Meone.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

07-03223	
Larry Gordon Johnso) [
4	ı

arry Gordon Jo		1- For State Certificate of Registrar		Reg.	
Physicia Ledical Exami		1. Decedent's Name (First, Middle,Last) Larry G. Johnson		2. Date of Death Month D April 27, 200	3. Time of Death
			o. City, Town, or Location of Deatl	<u> </u>	4c. County of Death
		8005 Douglas Avenue	Pikesville		Baltimore County
Funeral Director		5. Social Security Number $\begin{bmatrix} 6. \text{ Sex} \\ 1 \end{bmatrix} X_{\text{M}} = \begin{bmatrix} 7. \text{ Age (In yrs. last birthday)} \\ 47 \end{bmatrix}_{\text{Yrs.}}$	If Under 1 Year If Under 24Hrs Months Days Hours Mir	_ `	MM/DD/YYYY) 9. Birthplace (State or Foreign
		Usual Residence of Decedent		DEC 12	, 1959 Country) New York
v any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show d at once.	tor	MD Baltimore Milford Mi			1 Yes 2 X No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number 8005 Douglass Ave	10f. Zip Code 21244	10g	. Citizen of What Country?
with the 18 23a		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (S		USA 14. Race - American Indian, Black,
death or iten	Funeral	1 Yes 2 Y No	s, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.
rs after ural", miner	ā	3 X Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify: s Usual Occupation (Give kind of	work done	Specify: White 6b. Kind of Business/Industry
72 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	st of working life. DO NOT use ref		ob. Kind of Business/Industry
5-0036 led within 72 Hygiene. other than '	Completed	12 Cook			Deli
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	انه	17. Father's Name (First, Middle, Last) Warren M. Johnson		e (First, Middle, Ma Cia Johns	
212 ould be I Ments is mark	To B				er, City or Town, State, Zip Code)
MD nd 2 sho alth and m 27 is	1		Greegage Rd Wind		
Baltimore, permit. Pages I an Department of Her Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other	· · · ·	.	20c. Location - City or Town, State
Itim		4 Donation 5 Other Specify: Metro Crem 21. Signature of Funeral Service Licensee C. Todd Doing 22. No	natory, Inc 5/1	L/07	Baltimore, MD
Balti permit. Departm Imports injury o		21. Signature of Funeral Service Licensee C. Todd Dring Cre	eme and Address of Facility Pmation Society Frederick Rd 1	of Maryl	and, Inc.
Physician ~ /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause or each line.	e mode of dying, such as cardiac	or respiratory arrest	t, shock, or heart Approximate Interval Between Onset and
caminer		Immediate Cause (Final disease or condition resulting in death) a. Cocaine and methadone into Due to (or as a consequence of):	coxication		Death
		Sequentially list conditions, b			
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
ed isit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and inplietly filled in by the funeral director, page 2 should be detached for use as the burial - transit	ledical	X UNPENDED AMENDED 7 300 £ portME = 200			
68760, certificate be exending physician se as the burial -	Med	#23d,27,20d-1, PETTE, got IF FEMALE: 23c. If yes, outcome of pregnancy	5/ , 5/8/0/ TT		23d. Date of delivery
Sox 6876 leath certificate e attending phy for use as the	cian/M	past 12 months?	al death 3 Ectopic pregn		Month Day Year
Box e death c the atten ed for us	Physic	1 Yes 2 No 9 Unknown 9 Unknown	er (Specify)		
ires that the signed by lbe detach	by P	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		acco use contribute to the cause of death? 2 ✔ No 3 Probably 4 Unknown
ds, F equires een sign				24a. Was an	
COF	Completed			autopsy perform	prior to completion of cause of ed? death?
of Vital Records, g Physician: The law requir ther this certificate has been s neral director, page 2 should		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 ✓ Yes 2 No
Vita hysicia this cer	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Othor		esidence 6 🗸 Other: Scene
J Of Jing Pl After funera	Dn: T	27. Manner of Death 1 Natural 5 Paneling (Month, Day, Year) 28a. Date of Injury (Month, Day, Year)		28d. Describe ho	w injury occurred
Division rate of a process of a precedurate of a precess of a precedurate	ertification:	2 Accident Find 4/27/2007 Find 5:16		unknown 28f. Location (Str	eet and Number or Rural Route Number, City
Divi	ertif	Suicide 6 X Could not be determined (Specify) found in dwelling		or Town, Sta	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Sal C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr		d due to the cause(s) and manner as stated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation 29b. Signature and title of certifier	29c. License number		and due to the cause(s) 29d. Date signed (Month, Day, Year)
		200. Signature and the or outside	O.C.M.E.		April 28, 2007
		30. Name and address of person who completed cause of death (Item 23a)			
		Mary G. Ripple MD. Deputy Chief Medical Examiner 111	Penn Street, Baltimore, N	MD 21201	
St Regist		31. Date filed (Month, Day, Year) 32. Figistrar's Signature	AU.		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Jean Elizabeth Northfield Johnson Apri1 28, 2007 12:03P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min, 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Director 469-28-4133 Sept 3, 1930 Minnesota Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2921 N. Leisure World Blvd. #322 20906 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No <u>م</u> Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, Elementary/Secondary (0-12) College (1-4or 5+) County Health Dept. <u>Administrative</u> Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Gideon Northfield Mary Hazel Sabin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Clayton L. Johnson/husband 2921 N. Leisure World Blvd. #322 Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | May 1, 2007 Beltsville, MD 21. Signature Funeral Service Licenses 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardia - Palmoney Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed replacemen 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 No declary Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 Yes 2 No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft le Funeral Di letely filled ir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier med Direct 29c. License number 29d. Date signed (Month, Day, Year) 0050410 4/29/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 120 18101 Prace Philip Dr , Olay 20832 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 0 1 2007 Registrar

Division or Vital Records, P.O. Box 68760.

To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 0

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAY 01

em E. Woods, MP HYSICIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signatury and title of certifier

29a. Certifier

(Check only one)

Medical

32. Registrar's Signature 200 Market S

KEVIN WOODS, M.O. 4940 RASTERN AVENUE BAITIMORE, MD

29d. Date signed (Month, Day, Year)

APRIL 25, 2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

KES-600

				1 For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of I rtificate of			giene	7	13880
منار		Physic /Medi		1. Decedent's Name (First, Middle, Last Katharina Jane K					2. Date of Dea) ear	3. Time of Death
		Examir		4a. Facility Name (If not institution, give Joseph Ritchey Ho	street and number) Spice		Ва	or Location of Death altimore		4c. County	of Death	3 103 H
		Funeral Director		5. Social Security Number 217-16-5848 6. Se	7. Age	(In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb. 1	, 1924	9. Birthp Court Man	lace (State or Foreign try) cyland
		yland		10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
		e Mar	ctor	MD N/A			Baltimo	ore				1 XYes 2 □ No
		death with the Maryland ma 23a or 28a-f show Froust be notified at	Director	10e. Street and Number 2006 McHenry St			10f. Zip Code		1	0g. Citizen of W		1
		leath on 234	era		12. Was Decedent B	ver in H.S. 13		L223	posity Voc or No			tates
3	960	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other treumatic event, the Mudical Examinar must be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 AN If Yes, Give Year or Dates:	lo l	1 ☐ Yes 2 X No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Specify:	k, White,	
X	15-0	72 h	etec	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occup	during most of work	sing	16b. Kind of Bu	siness/Inc	dustry
S:OS AM	121	withir lene. then then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retire	_{d)} I Operator		Monto		57 1
5	DG 2	other	Be Co	17. Father's Name (First, Middle, Last)		DWI	cer board	18. Mother's Nam				y Ward
	ylar	Menta Menta arked atic e	70 E	John Nicholas Dorn				Matild	la Kathar	cina Mar	ie H	loerl
1	Baltimore, Maryland 21215-0036	and 2 shi balth and n 27 is m er treum		19a. Informant's Name/Relationship (Ty John L. Kelley - S	pe, Print) Son	19b. Mailir 120 (ng Address (Street Cycamore	and Number or Run Road, Cur	al Route Number tis Bay,	City or Town, S MD 212	State, Zip 226	Code)
10	ore	t of He If Item or oth		20a. Method of Disposition 1	emoval from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other place	ce)	Date	20c. Location - (City or To	wn, State
25/	Itim	it. Paritmen intant: njury		4 ☐ Dorfation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Loudon Pa				Baltimo	re,	MD
4	Ba	Depa Impo any i		21. Signature of Fulleral Service Licenso	201206		. Name and Addre	es of Facility A hur Sprin	mbrose H	Tuneral	Home	, Inc.
				23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	MD	Approximate
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Re		arcinon	ia				Interval Between Onset and Death
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	W	outed d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		, ouridoquarios 61).						
*	,	ate be executed hysicien and the burial-transli	Exa	resulting in death) Last		consequence of):						
7	876	ate hys	dlcal								_	
7	9 xo	eath certifi attending for use as	/Me	IF FEMALE: 23b. Was decedent pregnant 2:	3c. If yes, outcome o	f pregnancy			1100	23d. Date		
rina	$\mathbf{\alpha}$	t the d by the tached	by Physician/Me	in the past 12 months? 1 Yes 2 No 9 WUnknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Moni		ry Day Year
atharin	Division of Vital Records, P.O.	aquires tha en signed ould be de	ed by F	Part II. Other significant conditions con	tributing to death but	t not resulting in the ur	nderlying cause give	en in Part I.			oute to the	e cause of death?
A	ecc	e law re has be	Completed						24a. Was ar	V / Dr	ere autop	sy findings available
	al	n: The lifeete har. r. page							perform	ned2 de	ath?	2 □ No
	ξ	Physician: Tribis certificel	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	4 A D E D O 4 4 4 4 4	2 DOA Cthe	26. Place of Death				1/20050
	οl	g Physical dispersal di	n; To	27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury (Month, Day	28b. Time of	28c. Injun	4 Nursing Hol	me 5 Resider			Hospice
	Sior	Attending I r death. ector; After by the funer	catlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		Yes 2 □No				
	Divi	tal or Attendi rs after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	eet, factory, office	:	28f. Location (Str City or Town,	eet and Number State)	or Rural	Route Number,
		To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical	one)	ician: To the best of er: On the basis of e and manner state	my knowledge, death examination and/or inv ed.	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, da	use(s) and man ite and place, an	ner as sta id due to	ited. the cause(s)
		To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier			29c. License		1	d. Date signed		
		. 6	-	30 Name and address of	malatad		y z	4170		April 2	5,2	007
		10		30. Name and address of person who con	ichey the	ain (item 23a) (Type, F	N. Fut.	.4170 wst F	Baltina	M ave	0 2	1201
		Sta Registra	-	31. Date filed (Month, Pay Year) 1	2007 S2. Redistrar	s Signature	porte	01 1	ewi i i i w			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** Sarah E. Krout 26, April 3:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 317 Wyman Park Drive Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 V F Director 218-40-7789 96 Nov. 26, 1910 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Show 10d. Inside City Limits notified at Director MXYes 2 □ No Maryland N/A Baltimore 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 with pe 317 Wyman Park Drive 'natural", or items 23a dical Examiner must I 21211 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∏Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify White ģ 3X Widowed 4 ☐ Divorced Completed filed within 72 h I Hygiene. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Joseph Scott ages 1 and 2 should be not of Health and Ments is If item 27 is marked or or other traumatic events. Sarah Rhoads 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Gentile Daughter 7918 Ridgley Oak Road, Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department of Important: If any Injury or once. Moreland Memorial 5/1/2007 Parkville, Maryland 21. Signature Ineral Service Mcdn. 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. Baltimore, Maryland 21211 3631 Falls Road 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure—list only one cause on each line. Approximate Interval Between Onsetyand Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 (4. dau /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to indiceduate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dusito (or as a consequence off burial-tran Due to (or as a consequence of): Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 2 No certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1. Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, death.

Baltimore, Maryland 21215-0036

After t

Hospital or Attending 24 hours after death Funeral Director: filled in by the

completely To the I within 2

State Registrar

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Hennewilm 3730 Falls Rd, Baltimore, 31. Date filed (Month, Day, Year)

MAY 0 2007

6 Could not be determined

3 Suicide

29a, Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of certifier



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For State Registrar	State of Maryland / Dep	partment of Health and I	Mental Hygier	C 0 0 1	13882
ı	Physici /Medio		1. Decedent's Name (First, Middle, Last Peyton Michael	· Almer I	Crause	2. Date of Death Month	Day / O Year	3. Time of Death 08:39 M
	Examir		4a. Facility Name (If not institution, give	- 1	4b. City, Town, or Location of Death		4c. County of Death	210
	Funeral		5. Social Security Number 6. Se.	x 7. Age (In vrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birtho	lace (State or Foreign
	Director		hla 7	Yrs.	Months Days Hours Min. 4	(Month, Pay, Yea	07 Coun	try) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		1	0d. Inside City Limits
	e Man Se-f sh liffed	ctor	Maryland Can	rou 7	aneytown			1 □ Yes 2/2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 271s marked other then "naturel", or items 23a or 28e-f show or other traumatic event, the Madical Examinar must be notified at	Funeral Directo	10e. Street and Number 4710 Baptist	Road	10f. Zip Code 2.1.787	10g.	Citizen of What Coun	try?
	death ms 23	nerai	11. Marital Status		. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ	
36	s after , or ite	by Fu	Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 No Specify:	o rican, etc.)	Black, White,	nite.
21215-0036	2 hour	ted b	15. Decedent's Edu		edent's Usual Occupation	, 16b.	Kind of Business/Inc	
2	vithin 7 ne. hen "n e Mad	Completed	(Specify only highest grad	College (1-4or 5+) (Give	e kind of work done during most of won DO NOT use retired) \(\) \(\) \(\) \(\)	king	nla	
	filed v Hygie other t		17. Father's Name (First, Middle, Last)		18 Mother's Nam	ne (First, Middle, Maid		
Maryland	should be nd Mental marked o	To Be	Scott Mich	rael Krause	- Heid	i Lynn	Kenyor)
Mar	d 2 sho th and 7 Is mu traumu		19a. Informant's Name/Relationship (Ty Heidi Lynn Kenu		ling Address (Street and Number or Ru Baptist Rd, Ta	ral Route Number, Cit	y or Town, State, Zip MD 21	
	of Health item 27 other tr		20a. Method of Disposition	20b. Place of Disp			Location - City or To	
Baltimore,	Pages Iment of I tent: If it		1 ☑Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	Spring	ield Cemetery 41.	28/07 5	Sykesvil	lle, MD
Bal	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other once.		21. Signature of Funeral Service Licens Paigu Haight	Herbert	Page 195 Sy	Home & c	MB 217	P.A. 184
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ications that caused the death. Do not en ne cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Ī	Physician / /Medical		disease or condition resulting in death)	Due to (or as a consequence f):				
	Examiner	Ļ		b				
_	uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause Uniscase of July that initiated events	Due to (or as a consequence of):				
Ó	e exec	Exa	resulting in death) Last	Due to (or as a consequence of):				
38760,	icate b physic s the bi	dical						
Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached to: use as the buriat-transit	Physician/Med	230. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	Tratagia aranggay		23d. Date of delive	ry
0	ne deat the att	sicie	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		Month	Day Year
م.	ires that the dei signed by the a i be detached fi	y Ph		ntributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
ords	w requires been sign should be	Completed by	Cervical in con	rpetence		1 🗆 Yes	2 No 3 Proba	ably 4 Unknown
Seco	e lawr has be ge 2 sh	npie				24a. Was an autopsy	prior to con	osy findings available inpletion of cause of
tal	ysicien: The lav is certificate has director, page 2	e Col	25. Was case referred to medical		26 Plans of Day	performed 1 ☐ Yes 2 151	death?	2□ No
<u></u>	Physicie this cert al direct	ToB	examiner?	fospital:	Other	ome 5 Residence	6 ☐Other (Specify)
o uc	ing PI	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	jury occurred	
Division of Vital Records,	Attence r death sector:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st	M 1 ☐ Yes 2 ☐ No treet, factory, office	28f. Location (Street		Route Number,
	ital or A		4 Hornicide	building, etc. (Specify)		City or Town, Sta		
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier Check only one) Certifying Physical Examination (Check only one)	sicien: To the best of my knowledge, deal ner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, rvestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stand due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, L	Day, Year)
			Sili		D000496	4 '	1/24/0-	1
ý	Ø		30. Name and address of person who co	empleted cause of death (Item 23a) (Type,		ESTMINST	TR MA	21157
ľ	Sta	-0.0	31. Date filed (Month, Day, Year)	32 Registrar's Signature	L A	- 11.11.011	1110	00.
	Registr	ar	88AV 0 1 200	7 Bloom & K	and it			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 3883 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Patricia **Physician** Kinlein Month J. April 30 2007 6:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 300 Milton Court Glen Burnie Anne Arundel County If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2**X** F Director 212-36-3812 68 May 3, 1938 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or 18 new 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 1 Yes 2 No Director Maryland Anne Arundel <u>Glen Burnie</u> 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Milton Court 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status "natural", or iten dical Examiner Black, White, etc. 1 ☐ Yes 2 █****No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify \$ Specify: 3 □ Widowed 4 □ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 is marked other than 'r r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) N/ASelf Employed Care Giver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ William Dolphin Greene Wilma Frances 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond W. Griffiths (Son) 300 Milton Court Glen Burnie, Maryland 21061 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 5/1/07 Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licenses 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final S Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ending physician and use as the burial-trans Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed? certificate 1 □Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

State

Registrar

and title of certifie

4 ☐ Homicide

29a, Certifier

29b. Signatur

and manner stated.

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

OESLER

63145

29d. Date signed (Month, Day,

3

RD, GLEN

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death TH 2007 Solomon April Kaminsky 18:15 pM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hosp columbia Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1 M 2 □ F 168-16-3813 01/21/1915 PΑ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6410 SUMMER CLOUD WAY 21045 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SLIPCOVER CUTTER HOME FASHION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NATHAN KAMINSKY ANNA UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6410 SUMMER CLOUD WAY, COLUMBIA, MD 21045 of Disposition (Name of Date 20c. Location - City or Town, State JANIS KAMINSKY/DAUGHTER IN LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 X Removal from State ROOSEVELT CEMETERY 4 Donation 5 Other (Specify) 05/01/2007 | TREVOSE, PA 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. <u> TOWN ROAD - PIKESVILLE, MD 21208</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) near ongestive abele Due to (or as a consequence of)

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed

certificate ha

ours after death.

neral Director: A
filled in by the ft

Hospital

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "nature!" any injury or other traumatte excessions.

Physician

/Medical

Examiner

Funeral Director

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Completed

Be (

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Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

10a. State

MD

Funeral

Director

Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 2 Fetal death

3 ☐Ectopic pregnancy 5 Other (specify)

23d. Date of delivery

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24a. Was an autopsy 2 No 1□ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Day

25. Was case referred to medical examiner? 1 Tes 2 No

27. Manner of Death

2 Accident

3☐ Suicide

4 Homicide

1 Natural

5 ☐ Pending investigation

6 Could not be determined

Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown

29a. Certifier (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certif

5005

50870

3, goal Bell lane Clarksville MD 21029

20

State

Registrar

completely

Suzan 31. Date filed (Month, Day, Year)

MAY 0 1 2007

32. Registrar's Signature

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director Funeral 3altimore, Maryland 21215-0036 Completed by Be ၉ **Physician** /Medical Examiner Examiner The law requires that the death certificate be executed burial-transi and Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending asn for 1 the à þ Completed page 2 s certificate I Hospital or Attending Physician: Be P this Certification: After t the Funeral Director: Af 29a. Certifier Medical To the P within 24 To the F 29b. Signature and titl 30. Name and address of person

1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 26,2067 Stephanie Kurant 10:45PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ManorCare-Rossville Baltimore Rosedale | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan 25, 1916 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months 1 □ M 2 🔽 F 215-03-5480 91 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2 ☐ No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 607 South Wolfe Street 21231 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married White 1 ☐ Yes 2 Ho Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanislaw Kurant <u>Franczesca Kaczmalski</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Kurant - Brother 1206 Krueger Avenue Baltimore, Md. 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview_Crematory 4-30-2007 Baltimore, Maryland 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses kuld Dundalk Ave. Baltimore. Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No autopsy performed? Yes 2∐No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2[XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

4 Homicide



who completed cause of death (Item 23a) (Type, Print)

and manner stated

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

	·	1 - For State Registrar	State of Maryland	-	irtment of H			giene Neg. No.	107	13886
Physicia /Medic		Decedent's Name (First, Middle, Last) Marie Claire	Leary				2. Date of Dea Month April	Day 20	Year 007	3. Time of Death 7:30 am
Examin		4a. Facility Name (If not institution, give str 2000 Wilson Point I 5. Social Security Number 6. Sex	eet and number)	ast birthday)	4b. City, Town, or Middle If Under 1 Year	River	ath	4c. Cou	timore 9. Birthp	place (State or Foreign
Director		217–38–6352 1 N Usual Residence of Decedent 10a. State 10b. County	1 2 □XF 94	Yrs.	Months Days	Hours Mi	6/22/1	912		nsylvania Od. Inside City Limits
and 2 should be filed within 72 hours after deeth with the Maryland fleating and Maryland Hydrone. The marked other then "netural", or items 23s or 28s-1 show other traumatic event, its Medical Examb an insist to multified at	al Director	Maryland Baltimore 10e. Street and Number 2000 Wilson Point B		ldle Ri	Ver 10f. Zip Code 21220			10g. Citizen	of What Cour	1 ☐ Yes 2 📉 No
72 hours after deeth w	d by Funeral		. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			ispanic Origin? n, Mexican, Pui Specify:	(Specify Yes or No- erto Rican, etc.)	14. F	Race - Americ Black, White, acify: Whi	etc.
led within 72 h ygiene. her then "netu	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		(Give	ent's Usual Occupa kind of work done of DO NOT use retired aker	during most of w		Own	Home	iustry
2 should be filed within and Mental Hygiene.	To Be	17. Father's Name (First, Middle, Last) George Lynch 19a. Informant's Name/Relationship (Type	, Print)	19b. Mailin	g Address (Street a	Maria	ame <i>(First, Middl</i> e, nne Ganne Ru <i>ral Route N</i> um <i>b</i> e	on		Code)
00		Elaine Williams (Da 20a Method of Disposition 1 Burial 2 Cremation 3 Rer	20b. Pl	ace of Dispos emetery, crem	sition (Name of natory or other plac	θ)	ad Middle B/37	20c. Locatio	on - City or To	
permit. Pag Depertment Important: I any injury o		4 □ Donation 5 ☑ Other (Specify) ☐ 21. Signature of Funeral Service Licensee	1/2 5r.	Br 14	Name and Address uzdzinsk: U7 UId Ea	is of Facility i Funera astern 2	al Home P Avenue E	a ssex,		er, Marylan nd 21221
Physician /Medical Examiner		23a. Part1. Enter the disease, or combination shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	nev's	Diffee		ac or respiratory an	'e st,	3	Approximate Interval Between Onset and Death
bur bu	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events esulting in death) Last	Due to (or as a consequ							
eth certifi uttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 🗌	Ectopic pregnancy Other (specify)				Date of delive Month	ny Day Year
w requires that the de been signed by the a should be deteched t	۵	Part II. Other significant conditions contri	buting to death but not resu	Iting in the un	derlying cause give	en in Part I.				e cause of death?
	e Completed	25. Was case referred to medical					24a. Was a autop: perfor 1 🗋 Yes	med? 210 No	b. Were autop prior to con death? 1 ☐ Yes	psy findings available inpletion of cause of 2 No
ng Phys ftar this ineral di	atlon: To B	examiner? 1 Yes 2 No)
To the Hospital or Attendi within 24 hours attar death. To the Funeral Director: A completely filled in by the fu	I Certification:	3 ☐ Suicide 6 ☐ Could not be determined 29a. Certifier 1 【 Certifying Physic	28e. Place of Injury - At hor building, etc. (Specify,)			City or Tow	n, State)		l Route Number,
To the Hospitel or At within 24 hours affar of To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Examine one) 29b. Signature and title of certifier	ian: To the best of my know r: On the basis of examinati and manner stated.	ion and/or inv	estigation, in my op	pinion, death oc	curred at the time, d	ate and plac	manner as st e, and due to ned (Month, I	the cause(s)
5		30. Name and address of person who com		23a) (Type, F	orint)	2653	Y Lusein M	5/1	107	
Stat Registra		31. Date filed (Month, Day, Year) MAY 0 1 2007	32 Registrar's Signate		Dr. #1	05 10	usen M	クエ).	204	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LARKIN DOLORES 2,30A.M 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) enter Age (In yrs. 8. Date of Birth (Month, Day, NOV. 2 Months 1 M 2 XF Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Mayes 2 □ No more 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3 Widowed 4 Divorced Blac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Rehab 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sour 19a. Informant's Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryknoli 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 Removal from State Green Mount Crematory
22. Name and Address of Fability
30 Seph L. Russ
2222 W. North 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): INEUMON IA Sequentially list conditions, any leading to mind a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? REMORD MASCUAR OISEASE 1 ☐ Yes 2 No 3 Probably 4 Unknown 0)ISEASE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Physician /Medical Examiner Examiner

certificate be executed

Records, P.O. Box 68760.

or Vital

Division

To the Hospital or Attending

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any Injury or other traumatic event. Its Me

sician and burial-transit attending physician Physician/Medical the SS use detached for the þ page 2:

signed I certificate within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director.

Completed

Be

2

Certification:

Medical

ARTORL

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

MAY 01

29a, Certifiei

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

32. Registrar's Signature

140

29d. Date signed (Month, Day, Year)

Kamanany 3 Kangerag 31. Date filed (Month, Day, Year)

2007

Mortswest

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** -UE LLA Anvi 2007 LONG 27 ·bm /Medical 2327 N. Charles 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Charles Village BALTIMORE 57. NA are If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 7-3-1932 If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2□F 223-44-9143 74 Director N.C. Usuel Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥ Yes 2 No Funeral Director Md. NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1300 E. 35th Street 21218 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2√2 Married 1 Yes 2√2 No Specify: Specify: Be Completed by Black 3 Widowed 4 Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric 12th grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luella Jefferson Smith Herbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21218 1300 E. 35th Street, Baltimore, Md. Herbert H. Long Husband 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State tery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-4-07 Mem. Park Randallatown, King 22. Name and Address of Facility 21. Signature of Fune al Service Licensee March F.H. East MUL 21202 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ADDER CAYCINOMA **Examiner** Due to (or as e consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed ettending physician end for use es the bunal-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to tha causa of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? t∐Yes 2 ¥Nu 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No edical Certification: To this : After this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fun 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Dev. Year) 2007 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ar IMEN MARI 01 novih 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

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2007

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			for State	State of Me	ii y ta i		rtificate of		Wichtairi	6	100/	13389
			Registrar 1. Decedent's Name (First, Middle, Last,)			tinoato or	Doutin	2. Date of [Reg. No Death		3. Time of Death
ı	Physici		Walter		Le	e	SR		Apri	Day		1:15 py
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of Dea		, T	. County of Death	
			Baltimore VA	Medical	Cer	iter	Bal	timore			NIA	1
	Funeral		5. Social Security Number 6. Sec	7. Age M 2□F	(In yrs.	last birthday)	If Under 1 Yea Months Days			Birth Day, Year)	9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	JW ZUF	83	Yrs.			09.	14.19	23 VA	
	land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
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	th with	alD	1239 Silverth	orne Pr	ma	1	1	12.39		U	5A	
	dea dea	ner	11. Marital Status	12. Was Decedent E Armed Forces?		.S. 13.	Was Decedent of f Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or I	No-	14. Race - Americ Black, White,	
36	or It	y F.	1 Never Married 2 Married	1 Yes 2 □ N Yes, Give	0		1 □ Yes 2 N				Specify: 1	./
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Iteme 23a or 28e-f show int, the Medical Examinational be multified at	Completed by Funeral Director	3 Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:		16a Decer	dent's Usual Occi	unation		16b K	(ind of Business/Ind	ach dustri
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/lai	should be nd Mental marked o	To										
Maryland	S 42 52 52		19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailir	ng Address (Stree	et and Number or F	Rural Route Num	nber, City o	or Town, State, Zip	^
	1 and Health tem 27 other tr		Alvin J. Lee	150n	1001 5	1239	5 lue	rthorne	hoad	1	timore.	
Baltimore,	Pages 1 nent of H int: If Iter iry or oth		20a. Method of Disposition 1 △Burial 2 □ Cremation 3 □ F	lemoval from State	206. F	cemetery, crer	sition (Name of natory or other pl		Date	20c. Lo	ocation - City or To	wn, State
턡	tant:		' 4 □ Donation 5 □ Other (Specify)		40	arrisc			02.07	Qu	ings mi	115, mD
Bal	permit. Pages Department of f Important: If Ite any injury or of		21. Signature of Funeral Service Licens	**		22	Name and Add	ress of Facility VC	0			nd Service
			23a. Part1. Enter the disease, or compl	ications that caused	the deat	b Do not ent	ILILIE er the mode of th				Ustan	MD 21133 Approximate
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each lin	ө.		or the mode of d)	mig, sour as our die	io or roopiratory	411031,		Interval Between Onset and Death
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0	te be executed ysician and le burial-transit	EX	resulting in death) Last	Due to (or as a	conseq	uence of):						
3760,		cal		d								
Division of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certifica rideath. After After this certificate has been signed by the attending plots the funeral director, page 2 should be detached for use as it.	by Physician/Med	IF FEMALE:									
B0)	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth	2 ☐ Feta	I death 3	Ectopic pregnan	су			23d. Date of delive Month	Day Year
o.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at i 9□Unknown	ime of d	eath 5	Other (specify)					•
٦.	that the ed by detach	Ph	Part II. Other significant conditions con	ntributing to death bu	t not res	ulting in the u	nderlying cause g	iven in Part I.	23e. Dio	tobacco i	use contribute to th	e cause of death?
ds	uires sign ld be	d b	Hypernatrem	ia					1 [Yes 2	□No 3□Prob	ably 4 Donknown
CO	w require been si should I	lete							24a. Wt	as an	24b. Were auto	psy findings available
Re	he law e has age 2 s	Completed							aut per	topsy rformed?	prior to cor death?	npletion of cause of
ta	ysician: The is certificate hadirector, page	o i	25. Was case referred to medical				_	26. Place of De	ath (Check only	2 2 100	1 ☐ Yes	2L N0
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0	ng Phys ter this neral di		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28c. Inji		28d. Describ			,
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	To the Hoepitel or A within 24 hours after To the Funerel Directompletely filled in by	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	ner: On the best of	my kno examina	wledge, death tion and/or inv	occurred at the vestigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time	e cause(s) e, date and) and manner as st d place, and due to	ated. the cause(s)
	o the ithin i o the	Med	29b. Signature and title of certifier	and manner stal	ou.		29c. Licer	nse number		29d. Da	te signed (Month.	Day, Year)
}	F≯FZ		Me Mo				Pic	1640		A	1122	2007
			30. Name and address of person who co	mpleted cause of de	ath (Item	n 23a) (Tyne	Print)	318		MA	11 42	700 /-
	5		29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who con Richard Ericson 31. Date filed (Month, Day, Year)	MO 10	Nor	th Gr	epu St.	: Belt	imove	MD	2120	7
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	r's Signa	ture		,	1000			1
	Registr	ar	MAY 0 1 200	Late Berg.	a St	in Agent	MAC!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g867,05/01/07dhb
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Year SONNIE LEAR 4 22 2007 0906 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BATTIMORE CENITER UNIVERSIT OF MARY LAW D MEDICAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 21, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Months Days Hours 214-38-7997 65 Director 1942 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified at MD Director Anne Arundel Glen Burnie 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 327 King George Drive 21061 traumatic event, the Medical Examiner must U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No 'natural", or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 22 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) Floral Designer Decoration th and Mental Hygien 7 Is marked other to permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Bahnlein Viola Lee James ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert J. Lear Sr./Husband 327 King George Drive Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April 26, 2007 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Funeral Service Licensee anella WOI4 9 1 Second Avenue SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NECROTIZING MERLMONIA /Medical Due to (or as a consequence of): Heart Failure Examiner ASPIRAT Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No Vital 1□ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Division or this 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death uneral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 ☐ Homicide filled in 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 114408 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PERKINS 1105 PACA Floor BATTI MORE, JR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Amend #26, per MD, G867, 5/1/07 TT Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25 2007 **Physician** EIKACH CELDA APRIL 8:07A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 305 REDLAND BLVD., APT 402 ROCKVILLE MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/15/1910 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F Days Months Hours Min. POLAND 96 Director 212-76-1227 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ∐Yes 2 X No Director MD MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 REDLAND BLVD., APT 402 20850 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If frem 27 is marked other the any Injury or other treasment. OWNER GROCERY STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ KALMEN LEIKACH BATSHEVA SCHECHTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 REDLAND BLVD., APT 402, ROCKVILLE. MD MARSHA TISHLER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH TFILOH 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/27/2007 BALTIMORE, MD CONGREGATION 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Matt Levinson 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical s a consequence of) Examiner KONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year Day 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed to Part II. Other significant | o vitions contrib | g to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? à 2025t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe certificate I 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2410 1 ☐ Inpatient 2 ☐ EB/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending | within 24 hours after death. To the Funeral Director; After (Month, Day Year) 5 ☐ Pending investigation 1 Natural Injury 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2/ Medica/Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29d. Date/signed (Month, Day, Year)

State Registrar

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30. Name and address of per

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se of death (Item 23a) (Type

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32 Registrar's Signature

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BETHESDA MI) 20817

State of Maryland / Department of Health and Mental Hygiene UU 1 - For State Registrer Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8 200 40 /Medical Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Sh Convalescent No Home BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Ade (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Director 06/27/1922 PΑ 169-16-0162 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If liem 27 Is marked other than "natural, or Items 23a or 28a-f show any Injury or other treumatic event. If a Macies Examination and be notified a 1 Tes 2 No Director BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4730 ATRIUM COURT, APT. 424 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Specify À 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RICHARD LIGHT NINA SINKOV 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4730 ATRIUM COURT, APT. 424, OWINGS MILLS, MD 21117 DAVID LAZEROW / HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of BALTIMORE HEBREW 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 04/30/2007 REISTERSTOWN, MD CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mass Le 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** injun can /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached the 9 Unknown 9 Tunknown signed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 X No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 Yes 2 X No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: ဂ္ Nursing Home 5 Residence 6 Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of wath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Hatural 2 Accident 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 Tyes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only onel tle of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Na e in address of person who ompleted cause of death (Item 23a) (Type, Print) MNO 32) Registrar's Signature 31. Date filed (Month, Day, Year) State 0 Registrar

Decoderits Name (First, Middle, Last)		1 - State Registrar	yland / Department of Healt Certificate of Dea	th	eg. No.?	13893
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State

Registrar

Joan Milley

31. Date filed (Month, Day, Year) MAY 01

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29b. Signature and title of certifier

29a, Certifier

(Check only one)

Medical

32 egistrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muns, M.D

Loch Raven Blvd, Baltimore, MD 21239 5601

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29d. Date signed (Month, Day, Year)

			1 For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H rtificate of L			eg. No.	13895
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	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Dea		4c. County of De	
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	Director			1 X]M 2□F	80 Yrs.	Months Days	Hours Min			
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	ylan		10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
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	h the	<u>i</u>	10e. Street and Number		The state of the s	10f. Zip Code		1	0g. Citizen of What	Country?
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н				one cause on each lin	ine death. Do not ent	er the mode or dymi	g, such as cardia	ic or espiratory arre	351,	Interval Retuges
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		Registrar Decedent's Name (First, Middle)	, Last)		rtificate o	Death	2. Date of De			3. Time of Death
hysicia/ Medic/			Eleanor	М	erritt		Month 4	Day 25	Year 2007	D
Examin		4a. Facility Name (If not institution	, give street and number)	1.1		, or Location of Deat			ty of Death	1 12:33
		501 Dolphin		715	Balti			NA		
neral ector		5. Social Security Number 219-38-2143	10M 20E	In yrs. last birthday) A Yrs.	If Under 1 Year Months Day		8. Date of Bir (Month, Da	th ly, Year)	9. Birthp	place (State or Fore
JUI		Usual Residence of Decedent	Λ 0	4 Yrs.			4 1	1943		MD
1		10a. State 10b. County	1	Oc. City, Town or Lo	ocation				1	10d. Inside City Lim
other traumatic event, the Medinal Examinal trust to notified at	Director	MD	NA	Baltimo	re					XXYes 2 1
100		10e. Street and Number	Charle And	775	10f. Zip Code			10g. Citizen of		ntry?
	Funeral	501 Dolphin 11. Marital Status	Street Apt			1201		US		
	Fun	1 Never Married 2 Marri	Armed Forces?	91 111 0.5.	If Yes, specify Cu	of Hispanic Origin? (S uban, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Ha	ice - Americ ack, White,	
	þ	3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 No If Yes, Give Year or Dates:		1□Yes 2∏XN	lo Specify:		Spec	ity: B]	ack
	Completed	15. Decedent (Specify only highes	s Education t grade completed)	16a. Dece	dent's Usual Occ	supation ne during most of wor	kina	16b. Kind of E	Business/In	dustry
	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	ired)	g			
		8th grade 17. Father's Name (First, Middle, 1	NA NA		lousewi	18. Mother's Nan	a /First Adidula		ome	
	To Be	(,	ast) Unknown				Thoma		me)	
	. 1	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mailir	ng Address (Stre	et and Number or Ru			State Zin	Code)
1	1	Corinthia Wil	liams-Daugh	ter 392	8 Reis	sterstown	Road			D 21215
pnce.		20a. Method of Disposition XXBurial **Gromation**	2 🗆 🗆	20h Place of Dispo	sition (Name of	lace)	Date	20c. Location	- City or To	wn, State
		4 Donation 5 Other (Sp			emator		07	Balto	MD	
ğ		21. Signature of Funeral Service L	icensee	22	. Name and Add	-	March	F/H V	Vest	21215
1	-	1 nnel	WK Jme	2	4300 W	labash Av	enue	Balto	MD	21213
ı		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	omplications that caused the			ying, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
l		disease or condition resulting in death)	Prob.	caral	ac ar	rest				Chisor and Death
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:	dlcai		d	nosis	of C	iver				
	Physician/Me	IF FEMALE:	23c. If yes, outcome of s	Oregonancy.	0					
	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnan Other (specify)	су			ate of delive onth	ry Day Year
1	nys.	1 ∐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	5 5. GGaii. 5 _	Ciriei (specify)					
1	Dy P	Part II. Other significant condition	s contributing to death but n	ot resulting in the ur	derlying cause g	iven in Part I.	23e. Did to	bacco use con	tribute to th	e cause of death?
	ed .						1 □ Y	es 2 No	3 🗌 Proba	ably 4 □Unknov
	Completed						24a. Was		Were autor	osy findings availab
	5						autop perfor	med?	death?	npletion of cause o 2□ No
6	e C	25. Was case referred to medical examiner?	11			26. Place of Deat	11			
	0	1 Yes 2 No 27. Magner of Death	Hospital:	2 ER/Outpatient	3 DOA		me 5 Resid)
11.20		1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time of Injury	28c. Inju Wo		28d. Describe h	ow injury occur	red	
4120	Ica	3 ☐ Suicide 6 ☐ Could no	ot be 290 Place of Injury	At home, farm, stre		Yes 2 No	28f. Location (S	treet and Numb	har or Pural	Pouto Number
1	Certification;	4 Homicide determin	building, etc. (5	Specify)	-1, 144101), 011100		City or Tow	n, State)	Jei Oi Huiai	noute Number,
		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of m	y knowledge, death	occurred at the t	time, date and place,	and due to the c	ause(s) and m	anner as sta	ated.
3	Medical	one)	kaminer: On the basis of exa and manner stated	animation and of inv	estigation, in my	opinion, death occur	red at the time, d	late and place,	and due to	the cause(s)
12	2	29b. Signature and title of certifier	0.000	10		nse number		29d. Date signe		
		20 1	Upilly 1	10	j	018450 1kems p	1	4	127	107
	:	30. Name and address of person w		(Item 23a) (Type, F	Print)	Allena		- 0 L	41.0	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 04 23 2ÖÖ7 Janice Denise Montgomery 1:46p. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Nursing Home Towson Baltimore If Under 1 Year If Under 24 Hrs. **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months Hours Min. 1 □ M 🗶 🗆 F Director 213-62-5780 07 12 NC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1X Yes 2 No MD NA Baltimore filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 items 23a Funeral 5506 Belle Vista Ave 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 🎾 No Specify. þ Specify: Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than Elementary/Secondary_(0-12) College (1-4or 5+) 12th grade <u>2yrs</u> <u>Legal Assistance</u> Law Office 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Walter Witherspoon Virginia Simmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5506 Belle Vista ave, Baltimore, Md Melvin Wiggins Jr-Son 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 5/1/07 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21215 Baltimore, Md 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician correc NOW /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy ō in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1□ Yes 2 MNo or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ØOther (Specify) After this funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation s after death. death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760,

State Registrar (Check only

29b. Signatore and title of certifier

31. Date filed (Month, Day, Year) MAY 0

DHMH 17 Rev 1/2001

0

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANNES

my 6701 N. Charles St Tonson MO

29c. License number

058303

29d. Date signed (Month, Day, Year)

April 30 2007

				For State Registrar			State o	of Ma	rylan		artme e <i>rtifica</i>				lental Hy	giene Reg. No.	007	Programme and the second	13898)
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		To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burist-transit	Salo	29a. Certifier (Check only											and due to the					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Paul Eugene Milbrodt 26 300 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HUSPITAL BALTIMORE AGNES 6. Sex **X** M 2□ F if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 21,1923 Birthplace (State or Foreign Country) **Funeral** Hours Months Days **Director** 432-48-9156 Ark. Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 □Yes 2X No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane BRT05 21228 USA Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant if item 27 is marked other than "natural", or items 23 ury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No White ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Milbrodt Ola Sanders ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edna L. Milbrodt Wife 719 Maiden Choice Lane BRT05, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. 05/02/2007 Owings Mills, Maryland 4 ☐ Donation | 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service License 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Enter the disease of shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final CARDIOMYOPATH Physician 15 CHEMIC disease or condition resulting in death) in known /Medical Due to (or as a consequence of): Examiner ORONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence o) Examine that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buna Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Minknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has 2₩No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Thpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral 27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturai (Month, Day Year) 5 ☐ Pending investigation after death. i Director: A id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3□ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft To the Funeral Di completely filled in the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 0002100 APR 26,2001

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MILBRODT

State Registrar TENNE NGOUNCOA ate filed (Month Pay, Year) 2007 32 Agistra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

900 CATON AVENUE BAGIMORE, MD

21229

		4	For State Registrar	State of M	faryland / [Departm <i>Certific</i>			nd Mei		iene ¿ og. No.	07	139	00
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<u> </u>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpa	atient 2 ER/C	Outpatient 3[DOA Ot	han			ence 6 🗆 O	ther (Spec	city)	
Division of Vital Records,	ding Physician: The law requir h. After this certificate has been si funeral director, page 2 should		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of I (Month,	njury 28b. Day Year)	Time of Injury	28c. Inju			d. Describe h	ow injury occ	urred		
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∑ ×	or Atl	Certification:	4 Homicide determine	280. Place of	Injury - At home, etc. (Specify)	farm, street, f	actory, office		20	City or Tow	itreet and Nur n, State)	noer or Hu	rai nobie ivo	mber,
П	pital ours a ers! [29a. Certifier 1 Certifying	Physician: To the be	est of my knowled	ge, death occ	urred at the t	me, date and	place, an	d due to the	cause(s) and i	manner as	stated.	
	24 hc 24 hc Fun etely	Medicai	(Check only 2 Medical Ex	eminer: On the basis	s of examination a	and/or investig	ation, in my	opinion, death	h occurred	at the time, o	date and place	e, and due	to the cause	(s)
	To the Hospital or Attendi within 24 hours after death. To the Funers! Director: A completely filled in by the fu	Me	29b. Signature and title of certifier				_	se number)		29d. Date sign		_	
			Anu	Medi	cal Du	ten	D	03312	_		April .	26, 2	1667	
/	X		30. Name and address of person wh	no completed cause of	of death (Item 23a	(Type, Print		11 1		000	21266	/		
6), \		Allison Habas	SBALL 61	01 N.C	nance	She	KT 11	MYN	WD	(160			
18	Sta Regist	ate rar	31. Date filed (Molity, Pay, Yar)	2007	istrar's Signature	ben								

07-03066

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Michael Taylor Manega	n State of Maryland / Departmo or State Certification	ent of Health and Mental I ate of Death	Reg. No.	2007 1390
Re	lecedent's Name (First, Middle, Last)		Date of Death Month Day Year	3. Time of Death 2102 hrs
Physician/ 1. Medi~~! Examiner	MICHAEL TAYLOR MAN	EGAN	April 21, 2007	
48	Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	Frederic	
	Frederick Memorial Hospital 7. Age (In yrs. last bir	1711	Hrs. 8. Date of Birth(MM/DD/YYYY	9. Birthplace (State or Foreign N. Carolina
	Social Security Number $\begin{array}{c} 6. \text{ Sex} \\ 246-96-9645 \\ \end{array}$ $\begin{array}{c} 7. \text{ Age (In yrs. last bir)} \\ 50 \\ \end{array}$	(ilday)	Min. JULY 21,1956	Country)
U	ual Residence of Decedent Step 10b County 10c. City, Town	or Location		10d. Inside City Limits
* a		ederick		1 Yes 2 X No
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show unafte event, the Medical Examiner must be uotified at once. To Be Completed by Funeral Director	e Street and Number 3757 Spicebush Dr.	10f. Zip Code 21704		ed States
with the ss 23a or se uotific	Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		e - American Indian, Black, te, etc.
or ite	Never Married 2 Married 1 X Yes 2 No	1 Yes 2 X No specify:	Specify:	
tural".	15. Decedent's Education (Specify only highest grade completed) 16a	Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		usiness/Industry
5-0036 ed within 72 hours aftigence of the result of the r	Elementary/Secondary (0-12) College (1-4 or 5+)	Special Agent	U.S. G	overnment
within giene. her th	7. Father's Name (First, Middle, Last)	18.Mother's N	Name (First, Middle, Maiden Surnam	e)
215- be filed be filed or rked of rked of Be C	Warren R. Manegan	Marc 19b. Mailing Address (Street and Number	cene Taylor	wn. State, Zip Code)
212 ould be ould be d Ment s mark it ever	ga. Informant's Name/(classificing (1))	19b. Mailing Address (Street and Number 3757 Spicebush Dr.		
MD d 2 sho d 2 sho in 27 is aumat	Yan Manegan / Wife 20b. Plac	e of Disposition (Name of cemetery,	Date 20c. Location	n - City or Town, State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". Injury or other traumatic event, the Medical Examine. To Be Completed by	1 Burial 2 Cremation 3 Removal from State	natory or other place)	4-25-2007 Freder	rick,Maryland
time t. Pag tment trant: y or of	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Stauffer Funera	1 Home
Bal permi Depar Impo		1621 Opossumtow	m Pike/ Frederic	k, MD 21702
Physician	23a. P. Tri. Enter the dise-se, or complications that caused the death. Do failure. List only one cause on each line.			
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Ernanol incoxicaci	on complicating hyperter cardiovascular disease	nsive atherosclerotic	
, uninter	b			
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
ed nsit Examiner	Colsease or injury that initiated events resulting in death) Last			
0, sician and burial - transit	d			
0, be execut risician and burial - tra	X UNPENDED AMENDED #23a,27,28a-f, p	erME, g867, 5/2/07 TI	23d, Date	e of delivery
68760 ertificate b ding physi e as the bu	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregna	ricy 2 Fetal death 3 Ectopic	pregnancy Monti	h Day Year
Box 68760 e death certificate the attending physical for use as the bhysical for the bhysician	past 12 months? 4 Pregnant at time of deat			
b. Box (the death ce by the attence ched for use	1 Yes 2 No 9 Unknown g Unknown	ulting in the underlying cause given in Par		ontribute to the cause of death?
ords, P.O. B. v requires that the de speen signed by the should be detached i	Part II. Other significant conditions contributing to death but not res		1 Yes 2 No	3 Probably 4 V Unknown
Records, P.C. The law requires that freate has been signed it page 2 should be deter. Completed by			24a. Was an 24	 Were autopsy findings available prior to completion of cause of
cord law red has be 2 shot			performed? 1 ✓ Yes 2 No	death? 1 Yes 2 No
Vital Recontysician: The la		26.Place of Death	(Check only one)	
ician: s certi rector	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 🗸	ER/Outpatient 3 DOA Other	Nursing Home 5 Residence	
Physical disease of the physic		28b. Time of Injury 28c. Injury at Work		curred
on of anding Pt. tth. r: After ne funeral	1 Natural 5 Pending Fnd 4/21/07	Fnd 8:18 pm 1 Yes 2 X	CILC .	lumber or Rural Route Number, City
Division of Vital Records, tal or Attending Physician: The law requirents atter clear. After this certificate has been silled in by the funeral director, page 2 should be entification: To Be Completed	2 Accident Investigation 28e. Place of Injury - At ho 3 Suicide 6 X Could not be	me, farm, street, factory, office building, et	or Town, State)	Drive Frederick, MD
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funcara Director. After this certificate has been signed by the attending physicompletely filled in by the functal director, page 2 should be detached for use as the bedieval Certification: To Be Completed by Physician/Medical Certification: To Be Completed by Physician/Medical Certification:	4 Homicide determined (Specify) HOUSE 29a. Certifier 1 Certifying Physician: To the best of my knowledge	e death occurred at the time, date and pl	and me	anner as stated.
he Ho in 24 b he Fur pletely	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination are and manner stated	nd/or investigation, in my opinion, death of		
To the Ho within 24 1 To the Fu completely	and manner stated. 29b. Signature and title of certifier	29c. License number	r 290. Date	signed (Month, Day, real)
	austz	O.C.M.E.	April 22	2, 2007 —————————
	30. Name and address of person who completed cause of death (Item Ana Rubio MD. Assistant Medical Examiner	23a) 111 Penn Street, Baltimore, MD	21201	
0	Ana Rubio Mb. Acceptant			
Stat Registra	 	AT AGENTAL		

07-03130 Kirk A. Me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1-	For State of Maryland / Department of Health and Mental Hy For State Certificate of Death	Reg. I	Vo ZU	17 1390
Physician		egistrar . Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
Examine		Kirk Alan Mercer	Month Da April 23, 200	7	1850 hrs
**	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Lipiversity of Maryland Medical Center Baltimore		4c. County of Death	
	١,	Oniversity of Ividiyiana Medical Scritci	8. Date of Birth (N	MM/DD/YYYY) 9. Bir	thplace (State or
Funeral Director		Months Days Hours Min.	Oct 28,	Foreig	untry) MD
Birestor		2U-02-3831	OCT 20,	1933	· IID
any	_	0a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
* .	_	MD Howard Ellicott City			1 Yes 2 X No
faryla 28a-f	Director	0e. Street and Number 10f. Zip Code	10g.	Citizen of What Cou	ntry?
th the Maryland 23a or 28a-f show notified at once.		11900 Triadelphia Road 21042		USA	in a Disab
th with		1. Marital Status 1. Never Married 2 X Married 3 X Mar	ecity Yes or No- Rican, etc.)	White, etc.	ican Indian, Black,
er dea		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: wh	ite
urs afi tural' amine	େ⊢	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the complete of the complete o		6b. Kind of Business/	
72 ho	ompieted	Elementary/Secondary (0-12) College (1-4 or 5+)	(ed)	audio	
Nothin iene.	ĔĹ		(First, Middle, Mai		
21215-0036 uld be filed within 77 Mental Hygiene. marked other than c event, the Medical	86 86	7. Fattlet's Natile (11st, Middle, East)	Belle Pfe		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she marked other than "natural", and the month of the marked other than "natural".	라	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Rural Route Numbe	er, City or Town, State	e, Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'vi other traumatic event, the Oddical	-	Mrs. Helen Mercer (spouse) 11900 Triadelphia Rd.		t City, M	D 21042
Fe, Frank		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	20c. Location - City o	r Town, State
Pages nent of ant: J	Н	All County Cremation [4-2]		Sykesv <u>ille</u>	
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tringury or other traumant.	Ţ	21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHai			Chape1
	1	P.O. Box 195 Sykes 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	or respiratory arrest	t, shock, or heart	Approximate Interval
Physician ledical	-	failure. List only one cause on each line.			Between Onset and Death
.aminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries Due to (or as a consequence of):			
		Sequentially list conditions, b.			
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
1 - 5	хащ	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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876 tiffcat ng phy as the	<u></u>	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregn	ancy	Month	Day Year
Box 687 (seath certifice the attending place for use as the		4 Pregnant at time of death 5 Other (Specify)		į.	Y
D. BC the dea	Physician/Medical	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute f	o the cause of death?
ires that the signed by	2	,	1 Yes	2 No 3 Pr	obably 4 🗹 Unknown
ords, w require	Completed		24a. Was ar		autopsy findings available o completion of cause of
COL law r has b	힅		perform	ned? death?	
Vital Rec ysician: The l his certificate l director, page		25. Was case referred to medical 26.Place of Death (Check			
Vita hysician this cer	Be Be	Others	ing Home 5 F	Residence 6 Oth	ner:
1 of Ving Phy	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe he Subject drive	ow injury occurred or of vehicle in v	ehicular accident
ion itendii leath. for: /	aţio	2 Assidant Investigation			
	ပေျ	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		treet and Number of late) 395 @ Exit 18A, R	Rural Route Number, City andallstown, MD
ivision Tor Attendath The death Directors To by the	割		Cutchoop of t		
Division of Vital Records, ospital or Attending Physician: The law requir hours after death. Interal Director: After this certificate has been is y filled in by the funeral director, page 2 should be a second or the funeral director.	Certification:	4 Homicide determined (Specify) Interstate/Express	d due to the cause	e(s) and manner as st	ated.
Divis the Hospital or A hin 24 hours after the Funeral Direc		29a. Certifier (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the cause at the time, date a	e(s) and manner as stand place, and due to	ated. the cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Certifi	4 Homicide 29a. Certifier 1 Coefficient Physician: To the best of my knowledge, death occurred at the time, date and place, an	d due to the cause at the time, date a	29d. Date signed (A	the cause(s)
Divis To the Hospital or A within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier (Check only one) 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date a	ind place, and due to	the cause(s)
		4	at the time, date a	29d. Date signed (A	the cause(s)
	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimo	at the time, date a	29d. Date signed (A	the cause(s)
	Medical	4	at the time, date a	29d. Date signed (A	the cause(s)

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL **Physician** Year MOCZULICI JLLIAN 5:30 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTHWEST HOSPITAL BALTIMORE Randallstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Nov 10, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 M 2 XF 178-12-0179 85 Yrs PA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" -- " any injury or other traumatic event." 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Carrol1 Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5741 Kinsmen Courage Court 21784 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. White <u></u> Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic/Retail 12 Homemaker/Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Steinbrenner Amanda (Unknown) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert Moczulski (Son) 5741 Kinsmen Courage Ct., Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Nother (Specify) Entombment Evergreen Mem. Gardens 5/4/07 Finksburg, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & Sykesville, MD 21784 CHAPEL, PA (Box 195) (410)-795-1400 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the *m*ode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC PULMONARY FABROLIX þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed RHEUMATOIN ARTHAIT 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Thpatient ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DØ063430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSPITAL MEDICAL CENTER.

DHMH 17 Rev 1/2001

State Registrar (LAVITET KHUNKHON

31. Date filed (Month, Day, Year)

NORTHUEST

2. Registrar's Signature

death with the Maryland

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 26 Yea **Physician** Morcell 5:21 Terrell April 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Johns Hopkins Hospital 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Min Hours 1 2 F Director Maryland Aug 9, 1996 217-47-9666 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 □¥es 2 □ No Director NA **Baltimore** Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A 1213 Cobb Road 21208 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Xo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or iter any Injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Carolyn Lewis Duane Morsell ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1213 Cobb Road Baltimore, Maryland 21208 Duane Morsell Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Murial 2 ☐ Cremation 3 ☐ Removal from State 05/03/01 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Arbutus Memorial Park 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1814 coronary Anomalous 10 years **Physician** /Medical Due to (or as a consequence of): **Examiner** 10 cardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Cardiac CASSEST After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, uncal herriation Intracranal hemorrhage Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 № No 24a Was an autopsy performed? Yes 2 No Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 29a. Certifier 🕯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Concern Delfilan, GWN. Wilf Street Street 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM 2 per HYS . 2867, 5/2/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24Day Month Year **Physician** SHERMAN HASBROUCK MASTEN М 2007 2110 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth |
Months | Days | Hours | Min. | 9 / 2 5 / 1 9 2 0 Greater Baltimore Medical Center . Age (In yrs. last birthday) Baltimore 9. Birthplace (State or Foreign **Funeral** 11**∑**M 2□F NEW YORK 043-14-6800 86 Yrs. Director Usual Residence of Decedent death with the Maryland 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD BALTIMORE PARKTON 1 □Yes 2 □**X**0 Director 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code 16 STABLERS COURT 21120 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 NoWW I I If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: WHITE ۶ م Specify: 3 Widowed 4 Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COLLEGE PRESIDENT EDUCATION 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ZACK G. MASTEN LILLIAN RUSSELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20003 HUNT PASS CT. PARKTON, MD 21120 GARY MASTEN son 20b. Place of Disposition (Name of GREEN MOUNT other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/27/2007 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funera Peryce Ligensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. USUACO 16924 YORK RD. MONKTON, MD. 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia and Sepsis weeks /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): the attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE use a 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9☐Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes been . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? 2□ No 2 No XYes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer I Certification: (Month, Day Year) Natural 2 ☐ Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43003 April 25, 2007

10 *1

State Registrar Nathan A.

31. Date filed (Month, Day, Year)

MAY

1

6701 N. Charles Street, Baltimore, MD

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dunsmore,

M.D.

2. Registrar's Signature

		1 - For State Registrar	State of Marylar		artment of F		R	g. No. UU /	13906
Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Year	
/Medio Examir		Audrey 4a. Fecility Name (If not institution, give s Carroll Hospi	treet and number)	Marti	4b. City, Town, o	or Location of D		28, 200 4c. County of De Carrol	ath
Funeral Director	(ES - 4	Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24		9. B	irthplace (State or Foreign Country)
pu »		Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Lo	cation				10d. Inside City Limits
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death with the Maryland me 23a or 28e-1 ehow richart be notilized at	Funeral Director	10e. Street and Number 922 Shirley Ma	anor Road		10f. Zip Code	21136	1	0g. Citizen of What C	
be filed within 72 hours after death with the Marylan tal Hygiene. d other than "naturel", or iteme 23s or 28e-f show event, the Medical Exemiliar must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	2. Was Decedent Ever in I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub		? (Specify Yes or No- uerto Rican, etc.)	14. Race - An Black, Wh Specify: W	ite, etc.
within 72 ho lene. than "natur the Wedical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire Recepti	during most of d)	working	16b. Kind of Busines Bank	s/industry
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s 1 and 2 should f Health and Mer ltam 27 is marks other treumatic		19a. Informant's Name/Relationship (Type Paul M. Martin	ee, Print) Son	19b. Mailir 41 G	Jeffer	and Number of SON OV	r Rural Route Number 7al, York	City or Town, State, town Hei	Zip Code) 10598 ghts, NY
permit. Pages 1: Department of He important: if Itan any injury or oth		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	20b. Ca	Place of Dispo cemetery creat rrol1	sition (Name of matory or other pla Cremat	ion 4-	-30-07	20c. Location - City of Hampstea	
permit. Departr importa any inje		21. Signature of Fuperal Service License	iaus		Name and Addre		HOME Re	824 Reis istersto	terstown R wn, MD2113
Certificate be executed funding physicien and physicien and see as the burial-transit	Ilcal Examiner	23a. Par1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	ract		fechica		Interval Between Onset and Death
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requires that the de een signed by the s nould be detached t	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause giv	ven in Part I.			to the cause of death? Probably 4-XUnknown
The law ate has b page 2 sh	Completed						24a. Was a autops perform	y prior to ned? death?	
	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☑ No	ospital:	7.50/0.45-4	. all pos Ott	000	Death Check only on		
ding Phys h. After this funeral di	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	I 3 DOA	4 🗆 Nursii	ng Home 5 ☐ Reside	ince 6 LiOther (Sp ow injury occurred	өспу)
r Attendin er death. rector: Af	ertificatio	1.27 Natural 5 Pending investigation 2 Suicide 6 Could not be determined	28e. Place of Injury - At h	nome, farm, str	M 1 🗆	Yes 2 □ No		reet and Number or F	Rural Route Number,
To the Hospitel or Attending within 24 hours after death. To the Funarel Director: After completely filled in by the funer	edical Cer	29a. Certifier 18 Certifying Phys	ician: To the best of my kn	owledge, deatl	n occurred at the til	me, date and p	place, and due to the ca	tuse(s) and manner	as stated.
To the Hos within 24 h To the Fun completely	Med	29b. Signature and the of contifier	and manner stated.		29c. Licens	se number	2	9d. Date signed (Mor	oth, Dav. Year)
d		1			104	372	5	4/30/0	MO 21157
)		30. Name and address of person who con IANIQ MAIM	1000 19	Ricky	ie Ro	rad	Wester	ini)ter	MO 21157
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	est s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 27, 2007 2:25 A. SHARON April MENIKHEIM ANN **YMedical** 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner N/A1408 Lochner Road Apt. A Baltimore 8. Date of Birth (Month, Day, Year) March 7, 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 💢 F Yrs. 62 219-42-9510 1945 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1408 Lochner Road Apt. A Completed by Funeral U.S.A. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 years Own Home <u>Homemaker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Arnold Geneva Julian ဥ Gordon Meehling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra (husband) | 1408 Lochner Road Thomas A. Menikheim Baltimore, Maryland Apt. A 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Sparks, Maryland Jessops Methodist Cem. 5-1-07 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPONATREMIA Physician YEAR /Medical Due to (or as a consequence of) YEAR Examiner LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been simpled to the continuation of the continuat Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 2 No Month Day Year 5 ☐ Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation after death. 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) completely and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07 051715 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FAUS WAS 3730 3ATIMONE, MS Ko HIT GULATI, MA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

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	Examin	er	4a. Facility Name (If not institution	-		- 1-	4b. City, Town,		of Death			County of Deat	e City
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	performent of Health and Mental Highers. Described when the Industriant Calabration of Health and Mental Highers. Industriants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Examinar must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 1 Other (S _i		cen	netery, cren	Forest	ice)		2,2007		ation-City or ngs Mil	lls, MD.
ב ב	Departiment Import any inj		21. Signature of Funeral Service	Licensee A	mell	Jy 22	Name and Addr onnelly 1	ess of Facili Funera ers Pc	il Hor	me Of D Road, D	unda unda	lk,P.A. lk, Md.	21222
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	The fact hospital or treatment of the fact has been signed by the fundate of executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical	(Check only 2 Medical one)	g Physicien: To the Exeminer: On the ba and mann	sis of examinatio	edge, death n and/or inv	occurred at the trestigation, in my	ime, date ar opinion, dea	nd place, a ath occurre	and due to the coded at the time, d	ause(s) a late and p	and manner as place, and due	s stated. to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Пач Month Year **Physician** Virginia Hanauer Nitsch Poril 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F 214-01-7441 Director 87 Sept.26, 1919 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Baltimore Director Maryland Catonsville 1 ☐ Yes 2 No 10e. 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Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George N. Hanauer ပ Olivia Zeller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary G. Serviente Daughter 844 Opossum Lake Road; Carlisle, PA 17015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Metro Crematory 4/30/2007 4 ☐ Donation | 5 ☐ Other (Specify) Catonsville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service/Licenses 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part1. Ent if the disease of complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner renal Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed coronary sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician andiac Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No detached for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by t Id be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes ■ No 24a. Was an has autopsy performed? (es 22 No this certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

To the within 2

State Registrar 29b. Signature and title of certifier

misbu filed (Month, Day, Year)

MAY 0 1 2007

29c. License number

East University Pkwy Baltimore,

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			FOI	State of Ma	ryland					Mental Hy	giene			
			1 - State Registrar			Cert	ificate	of D	eath	O Date of D	Reg. No.	200	3. Time of D	
	Physicia	an	Decedent's Name (First, Middle, Last)							2. Date of De		007 Yea	r	
	/Medic	al	Gai Nguyen 4a. Facility Name (If not institution, give stre	and number			4h City To	own or i	ocation of Deatl	April 2	-	County of De	20:20	J ;
	Examin	er	Montgomery General				Olney					ntgome		
	Funeral		5. Social Security Number 6. Sex	7. Age	-	st birthday)	if Under 1	Year	If Under 24 Hrs.	8. Date of Bi	rth	9. B	irthplace (State or Country)	Foreign
	Director		219-29-4516 1 ¹	1 2 ⊠ F	89	Yrs.	Months	Days	Hours Min.	Dec. 1	19	17 V.i	etnam	
Pu			Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Loc	ation						10d. Inside City	/ Limits
aryla	shov d at	_			·								1X Yes	
the M	28a-f otifie	Director	Maryland Montgomer	У	Gai	thersb	10f. Zip C	Code			10g. Citi:	zen of What	Country?	
with	a or	Ö	8 Bookham Court						0877		-	ed Sta		
death	ns 23 mus	Funeral		. Was Decedent E	ver in U.S	. 13. W	/as Decede			Specify Yes or N to Rican, etc.)	0-	14. Race - Ar Black, W	nerican Indian,	
after	or ite	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🛣 N If Yes, Give	lo		Yes 2	_	Specify:	to nican, etc.)		Specify: A		
Suno	ral", c Exar	d by	3 Midowed 4 ☐ Divorced	Year or Dates:							1 101 10	-2-1-1-1		
72 h	"natu	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)		16a. Deced	ent's Usual aind of work O NOT use	Occupat done du retired)	tion uring most of wo	rking	16b. Ki	nd of Busines	ss/Industry	
within A	than	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Homem	_				Ow	n Home	<u>.</u>	
filed	Hygir Sther snt, th		17. Father's Name (First, Middle, Last)		1.				18. Mother's Na	me (First, Middle				
ld be file	ked c	To Be	Quang Nguyen						Ве Но					
shou	s mar umat	-	19a. Informant's Name/Relationship (Type	. Print)		19b. Mailin	g Address (Street a	nd Number or R	ural Route Num	ber, City o	r Town, State	e, Zip Code)	
, MI	ertra		Quang Bui/Son-in-La	w						hersbur				
ore Jes 1	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer	moval from State		ace of Dispos		e of her place) May	Date 6,			or Town, State Maryland	
Dallillor Dermit. Pages	tment tant: jury o		4 ☐ Donation 5 ☐ Other (Specify)		Cr	tgomen emator		Inc.	20	07	1			
od II	Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Euroral Service Licensee	111	- MO 1	Ro	CKVII	le,	Inc. 30	0 West 1	Monte	omery	uneral H Avenue	11.071.00 B
		_	23a Part1 From the disease or complica	ations that caused					Marylan		arrest,		Approximate Interval Betw	
		XZ X	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final	cause on each lin	ie.	h		, ,					Onset and D	eath
	ysician Medical		disease or condition resulting in death)	Du ito (or as	a consequ	ence off:		-					John M	Rek
E	aminer		h h											
T.	±	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence of):								
ox 68/60, certificate be executed	attending physician and for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	2.0000000	ance of):								
be ex	cian a		looding in doday	Due to (or as	a consequ	ence or).								
icate be	physi s the I	dical	d.											
Sertif	nding use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome			-				0	23d. Date of	delivery	
death cel	atte	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant at			Ectopic pre Other (spe					Month	Day Y	ear/
j ş	y th	hys	9 Unknown	9□Unknown										
I Hecords, P The law requires that	been signed by the should be detached	by P	Part II. Other significant conditions conti	ributing to death b	ut not resu	Ilting in the ur	nderlying ca	use give	en in Part I.		tobacco Yes 2	,	e to the cause of de Probably 4 ∑U	
Hecords, he law requires t	een si tould l													
e law	nas be	Completed								24a. Wa	is an opsy formed?	24b. Were prior deat	e autopsy findings a to completion of ca no	available ause of
E -	cate l									1□ Yes	2 ₩ 100			
VITal iclan: ⊺	s certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	ospital:		55/0 1	4 0000	Othe	or.	eath Check onl	1.7.7.	a Cart	2	_
P y	r this rai dii	<u>۲</u>	1 Yes 2 No	28a. Date of Inju	ıry	ER/Outpatier 28b. Time of		8c. Injury Work		Home 5 ☐ Re 28d. Describ		-	Бреспу)	
	th. : Afte s fune	tion	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	м		<br Yes 2 □ No					
DIVISION I or Attending	ector by the	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inj	ury - At ho	me, farm, str	eet, factory,	, office		28f. Location City or 7	(Street a	nd Number o	r Rural Route Num.	ber,
	al Dir ed in	Certification:									-			
Hospi	within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, I	Medical	29a. Certifier 1 Certifying Physic (Chack only one) 2 Medical Examin	ician: To the best er: On the basis o and manner st	of examina	wledge, deat tion and/or in	n occurred a vestigation,	at the tim , in my o	ne, date and pla- pinion, death oc	ce, and due to the curred at the time	ne cause(s e, date an	s) and manne ad place, and	r as stated. due to the cause(s	.)
o the	vithin Fo the	Mec	29b. Signature and title of certifier	^			29c.	License	number		29d. Da	ate signed (M	onth, Day, Year)	
) [1		Maheteme P	sayeh >	2		\mathcal{D}	200	45+9		04	12817	500	
1	7		30. Name and address of person who cor	npleted cause of c	death (Item	23a) (Type,	Print)		1 1		10	*A-	2222	
~			MITHERE B	HILK- 32. Registr	18	191-1	Time	eQ 1	Philip	Drive	DIV	ey, [1]	7 50879	
	St	ate	31. Date filed (Month, Day, Year)	32. Registi	iais signa	75 89						,		

DHMH 17 Rev 1/2001

amend item 1 per fth 8867 Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Alyce Scott Nordback Clare Month **Physician** APri 24 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1+1 N/Aer 1 Year | If Under 24 Hrs. Hospital Age (In yrs. last birthday The Johns Hopkins Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours Months Days Min 1 □ M 2 🔽 F 60 Jan 5. 1947 Virginia 213-48-7225 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a State 10b. County 1 X Yes 2 No Palm Beach Florida Director Palm Beach Co. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 33480 "natural", or items 23a 400 South Ocean Blvd., #21 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ∏X No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event. the M. Ambassador's Spouse Foreign Service 3 yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elisabeth McKeown Donald Bruce Scott 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SE-11459 Stockholm, Sweden <u>Karlavagen 85,</u> Magnus Nordback (Husband) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 5/1/2007 Baltimore, Maryland 21. Signal Fine al Service in see 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC BREAST CANCER 2.5 years Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4⊡Pregnant at time of death 5 Other (specify) P.0. detached 9□Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 □ No 3 Probably 4 ☐Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐ No 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Injury 5 Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 APRIL 24, 2007 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) 15 JUSE VARCEAS, MEDICAL DOCTOR, THE JOHN'S HUPKINS HOSPITAL, GOONON'H WOLFE STREET, BALTIMALE, MARYLAND 21287 31. Date filed (Month, Day, Year) State MAY 012007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician Month Year Clarence David 0wens 2007 /Medical 4b. City, Town, or Location of Death 4a. Eacility Name (If not institution, give street and number) 4c. County of Death Examiner Nes Temore Birthplace (State or Foreign Country) Sex 1 M 2 □ F **Funeral** 10/12/1947 Hours Months 212-48-1031 MD Director 59 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Examiner must be notified at 1√ Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ō 4404 Cedar Garden Road 21229 USA items 23a Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) was Decedent Ev Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Black, White, etc. 1 □ Never Married 2 □ Married SpeAfrican American Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: þ 4 Divorced 3 Widowed Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. flagger Reliable Construction Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Moses Owens ပ Beatrice Husen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is any injury or other trai Mary Owens - McClary / Ex-Wife 1107 North Mount Street; Baltimore, Maryland 21217 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Garrison Forest Vet. Cem. 05/07/2007 Owings Mills, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ovenary Arteriosclevotic Vasallar Unknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician ivision or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed certificate 2 No 1 Yes 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 □ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 Natural Iniury 5 Pending To the nous after oc...
To the Funeral Director: After the Funeral Director: After the filled in by the fill 1 ☐ Yes 2 ☐ No investigation **∠** Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08055849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Avenue Serg esun 31. Date filed (Month, Day, Year) State MAY 0 1 2007 Registrar

			State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygie		13913
	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Med		Mildred Olivia Poteet			2007	6:40 A M
	Exami	ner	4a. Facility Name (If not institution, give street and number) Riverview Care Center	4b. City, Town, or Location of Dea	th	4c. County of Death	
	F		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	ESSEX If Under 1 Year If Under 24 Hrs	8 D / D	Baltimo	
	Funeral Director		218 10 7019 1 M 2 M F 84 Yrs.	Months Days Hours Min		9. Birth	nplace (State or Foreign intry)
	D		Usual Residence of Decedent		bary 27,	1722 INGM	Jérsey
	arylar how	_	10a. State 10b. County 10c. City, Town or L	227			10d. Inside City Limits
	he M	ecto		sex			1 ☐ Yes 21 No
	a or 2	Funeral Director	10e. Street and Number 1 Glenwood Road	10f. Zip Code 21221	10g	Citizen of What Cou	untry?
	ne 23	erai				USA	
ယ	or Iter	핕	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛱 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	14. Race - Amer Black, White	
Ö	ref. o	by	3 🖾 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Wh	ite
5-0	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "naturel", or Iteme 23a or 28e-f show event, I're Medical Exercipar must be notified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv	dent's Usual Occupation a kind of work done during most of wo DO NOT use retired)	rking 16t	o. Kind of Business/li	ndustry
121	within lene. then	g		DO NOT use retired) Iomemaker		rm Hama	
d 2	Hyginther Ther	ပိ	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai	Own Home	
an	should be id Mental marked o matic eve	To B	Michael Cornelius Rogers	Olive (den Sumame)	
Maryland 21215-0036	2 should I and Meni ie merked	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ng Address (Street and Number or Ro		itv or Town, State, Zi	p Code)
	12 B B			Matzon Rd.Baltimo			,
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State	osition (Name of matory or other place)	Date 200	Location - City or T	own, State
Ë	Pag tment tant:		4 Donation 5 Other (Specify) Parkwood	Cemetery 5/2/	2007 E	Baltimore,	Maryland
Bal	permit. Pages Department of t Important: If its eny Injury or of		21. Signature of Funeral Service Licensee	2. Name and Address of Eacility PUZOZINSKI FUNETA 407 Old Eastern A	l Home P.A	١.	
	_		238. Harti, Enter the disease, or complications that caused the death. Do not en	407 Old Eastern A	venue Esse	ex, Maryla	
	Physician		Immediate Cause (Final	1 1	1		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):		0,100		un-Known
	Examiner						
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events				
	and end l-trans	Examiner					
8760,	ate be executed hysician and the burial-transit	Ical E	Due to (or as a consequence of):				
687	flicate p phys		d				
Вох	n cert	D/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	200
m.	death	sicia	in the past 12 months? 1	Ectopic pregnancy Other (specify)		Month	Day Year
P.O.	res that the death certific igned by the attending p be detached for use as	Physician/Med	9 □ Unknown 9 □ Unknown				
Ś	res th signed	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the	ne cause of death?
Division of Vital Records,	w require been si should t	Completed	Anoma, CKD, GB	RD, MSCVD	1 🗆 Yes	2 No 3 Prob	pably 4 Quinkhown
ဋ္ဌ	elaw hast je2s	훁			24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
<u>a</u>	n: Th ficate r, pag				performed 1 ☐ Yes 2 💆	? death?	
₹ :	s certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient	04	th (Check only one)		
jo i	g Phy erthis eral c	E L	27. Manner of Death 28a. Date of Injury 28b. Time of	A SU DOA 4 Mursing H	ome 5 Residence		y)
<u>ö</u> :	uttendin death. ctor: Aft y the fun	atio	1 ⊠Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		(2.)	
ž į	r Atterdering the delinector	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street	and Number or Rura	l Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funerie Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit				City or Town, St.	•	
	24 ho 24 ho Fun etely f	Medicai	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death (2 ☐ Medical Examiner: On the basis of examination and/or interpretated.	noccurred at the time, date and place, restigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as si and place, and due to	ated. the cause(s)
;	To the	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
ľ	0		M.D	D-3875			
K	,		30. Name and address of person who completed cause of death (Item 23a) (Type,	D-3875 ASTBRN BLI			
				ASTBRN WU	10, 10	10-212	221.
	Sta Registra	~	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Paraham 2007 7 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ospita more 9. Birthplace (State or Foreign Year) **Funeral** 1 № M 2 🗆 F So North Car Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No NIA ma. **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number Was Decedent Ever in U.S. Armed Forces?/ 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) stallan 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be araha 1 ayLoR P ami 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) brother mull Taraham 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State -07 4 □ Donation 15 □ Other (Specify) FREdHILTON Paso 21. Signature Juneral Service Ucens 2 Name and Address of Facility 23a. Party Epide the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. P. march Funeral Home Backo md. 21229 Approximate Interval Between Onset and Death Immediate C. I.se (Final disease or Indition resulting in death) 20 hours Physician spirator Du tr (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 npatient Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After (Month, Day Year) Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Justin Bachmann, Medical Doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Justin Bachmann

32. Registrar's Signature SHEWA!

Res-000

The Johns Hopkins Hospital, 600 North Wolfe Street, Boltimore, Maryland 21287

April 27,

DHMH 17 HeV 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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δα D	3 Widowed 4 Divorced	Year or Dates	S:											
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e e	17. Father's Name (First, Middle, Las	st)					18. Mothe	r's Name	(First, Middle,	Maiden	Sumame	1)		
0	Frederick A. Pet	ersam					Hilda	a Cas	ssat					
	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	l Route Numbe	er, City or	r Town, S	State, Zip (Code)	
	Alfred J. Peters	am (Brothe	er)	2305	Carlo	s Ro	ad Fa	11st	on, MD	2104	47			
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0	25. Was case referred to medical					_	26. Place	of Death	(Check only o	ne)	***			
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5	1 Matural 5 ☐ Pending	(Month, E	Day Year)	28b. Time of Injury					28d. Describe h	now injury	y occurre	d		
÷ II	3 ☐ Suicide 6 ☐ Could not	be 390 Place of I	Injury - Al ho	me farm str			62 2 🗆 1		28f Location /	Street are	d Numbe	r or Rural	Boute Num	her
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eruncati	4 Homicide					at the tim	e. date and	d place, a	and due to the	cause(s)	and man	ner as sta	ted.	.)
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Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25c. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown 26c. Place 27c. Manny: Death 1 Matural 5 Pending investigation 28a. Date of Injury (Month, Day Year) 28a. Date of Injury - Al home, farm, street, factory, office	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. Place of Death to Month, Day Year) 27. Manny Death Yes 2 No 28a. 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Was case referred to medicat examiner? 1 Yes 2 No 3 Probably 4 Unknown 26. Place of Death (Check only one) 27. Manny Death 1 Natural Simple Death Part II. Inpatient 2 Pk/Outpatient Simple Death Simple

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wanda Peterson	1- For State of Maryland / Department of Health and Memaring	Reg. I	$_{No.}$ 201	17 1391
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adical Examiner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
	Johns Hopkins Hospital Baltimore			100000
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.		MM/DD/YYYY) 9. Bir Foreig	Inplace (State or untry) N.J.
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Information (S	Rural Route Number	er, City or Town, State	e, Zip Code)
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.	Emma Peterson - Mother 3411 Teresa Court 20a Method of Disposition (Name of cemetery,	Balto Date	Oc. Location - City of	7 Town, State
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Physician: This certical director	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nurs	•	Residence 6 Oth	er:
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		nd due to the cause d at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
To the Ho within 24 To the Fu complete!	29b. Signature and title of certifier 20b.		29d. Date signed (A	
	Josha Jeel up O.C.M.E.		April 25, 2007	
d	30. Name and address of person who completed cause of death (Item 23a)	4D 21201		
0	Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, No. 31. Date filed (Manth, Day, Year) 32. Degistrar's Signature	AD 21201		
Sta Registr	3.			
DHMH 17 Rev 1/200	MAY O I 2001			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 200 /Medical 4a. Facility Name (If not institution, give street and number) Examiner KONTHWEST CEN TO TOUN If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 1 F Months Hours 214-26-7243 Nov 6, 1929 MD Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. em 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3407 Santee Road 21236 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify <u></u> 3 ☑ Widowed 4 ☐ Divorced white Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Walker Mildred Holbrook 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and ... ment of Health an Lester F. Pague, III 3407 Santee Road, Perry Hall, Md. 21236 son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State = 0 permit. Page Department of Important: If any Injury or Woodlawn Cemetery 4/27/07 Woodlawn, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Loring Byers Funeral Directors Han Inc., 8728 Liberty Rd., Randallstown, Md. 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE **Physician** CEREBROVASKINA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dive to for as a ponser tience of Examiner the death certificate be executed burial-transi Due to (or as a consequence of): nding physician ause as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant atten for u 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 🗷 No Ö been signed by the should be detached 9 ☐ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 CONGESTICE DEGIDA 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. 24a. Was an has autopsy page this certificate PHOEMAKER AORTIC 1□ Yes 2 **H** or Vital ANES HESTE 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 ☐ Yes 2 N 1 7 Inpatient 2 ER/Outpatient 3 DOA ٩ 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After Division or Attending 1 Natural 5 Pending investigation 1 Tes 2 🗆 No death. 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L the Hospital 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

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State Registra

31. Date filed (Month, Day, Year) MAY 0

B

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CONTNA Registrar's Signature

ORIGINAL

29c. License numbe

DHMH 17 Rev 1/2001

DRIANDO

29b. Signature and title of certifier

07-03210 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Brandon Joseph Peyton State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 27, 2007 1014 hrs Medical Examiner Brandon Joseph Peyton 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 3347 Carrison Circle 160 Branchwood Court Harford Abinadon 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours Min. Director 213-33-4094 1 XM 2 F Country) Maryland 15 26, 1991 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. Yes 2 X No Maryland Harford Abingdon Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene.

nnt: If iten 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 3347 Garrison Circle 21009 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. tem 27 is marked other than "natural", or items traumatic event, the Medical Examiner must be. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Yes 2 X No Yes 2 X No specify: Widowed Divorced If Yes Give Year Specify: White 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 10 Student High School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent Joseph Burton Angelia Marie Peyton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B Darvl Newell /Legal Guardian 3347 Garrison Circle, Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition Date Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State tant: Gardens of Faith Cem. 5-2-07 Baltimore, Maryland Donation 5 Other Specify 22. Name and Address of Facility McComas Funeral Home, 1317 Cokesbury Road, 21. Signature of Funeral Service Licensee Abingdon, Maryland 21009 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death a. Hanging Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated 1/2 Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical attending physician a for use as the burial -AMENDED prMe,g867, 5/1/07 TT UNPENDED Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Day Fetal death past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Q Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. 2 Yes 2 ✔ No 3 Probably 4 Unknown Completed page 2 should has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate 1 V Yes After this certifi-funeral director, Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ဂ္ 1 V Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Subject hanged self FOUND: 1 Natura' Yes 2 V No Pending To the Funeral Director: completely filled in by the Apr 27, 2007 1010 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 160 Branchwood Court , Abingdon , MD determined (Specify) Woods 4 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 28, 2007

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

Laron Locke MD. A
31. Date filed (Month, Day, Year)

MAY

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111 Penn Street, Baltimore, MD 21201

me and address of person who completed cause of death (Item 23a)

2007

Assistant Medical Examiner

32. Registrar's Signature

07-02930 Mariem J. Pasingda Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 13919

	1 3 . 1 a 3ii i	·9u·		For State Certificate of Death		eg. No.	Lo Time of Death
	Physici	an/		egistrar . Decedent's Name (First, Middle,Last)	2. Date of Dear	Day Yea	3. Time of Death 2153 hrs
?	Exami		r	Mariam James Pasingda Mariem James Pasingda 4b. City, Town, or Location of Deat	April 16, 2	4c. County	of Death
			48	a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital 4b. City, Town, or Location of Deat Baltimore		N/	A
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	Director			213-75-8509 ALC 1 M 2 AF 138 118 1	021221	2000	
	ŕ			Journal Residence of Decedent 10c. City, Town or Location 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 No
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	rylan ta-f sl	1 5	11	IOe. Street and Number		10g. Citizen of W	
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	with t 1s 23a se not	3		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	Specify Yes or Norto Rican, etc.)		e - American Indian, Black, te, etc.
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Š	5-00.50 led within 72 hours after Hygiene. other than "natural", the Medical Examiner		najaidwo	17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Last)	ame (First, Middle	, Maiden Surnam	e)
1	Z1Z15-00350 und be filed within 72 hours afte Mental Hygiene. marked other than "natural", event, the Medical Examiner.		8 J	Inner Degineda Avak	Deng		2) - 1 - 7 - 0 - do)
è	MID Z1Z19-UU30 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she manic event, the Medical Examiner must be notified at once	5	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street and Number of	or Rural Route No	umber, City of 10	wn, State, Zip Code)
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3	Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thin ining or other traumatic event, the Modining on other traumatic event, the Modining or other traumatic event.		Ţ	21. Signature of Funeral Service Licensee	defeld F	uneral H	Home, Inc. MD 21212
_ '			4	23a Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	ac or respiratory a	arrest, shock, or h	neart Approximate Interval Between Onset and
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	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	y fille			e, and due to the	cause(s) and ma	nner as stated.
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	To To	COU	Mec	29b. Signature and title of certifier/ 29c. License number		29d. Date	signed (Month, Day, Year)
-				O.C.M.E.		April 17	, 2007
	AT			30. Name and address of person who comilete, cause of death (Item 23a)	ID 21201		
	U			Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	1D 2 120 1		
		9	tate	a 31. Date filed (Month, Day, Year) 321 Registrar's Signature			

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene

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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	place (State or Foreign ntry)
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<u>a</u>			19a. Informant's Name/Relationship (Type, Pr				t and Number or Rui				p Code)
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ore	ges 1 and of the trial of the corothe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov	al trom State		tion (Name of tory or other pla		Date			
Ξ			4 ☐ Donation 5 ☐ Other (Specify)	Cres		Mem. Ga					ville, MD
Baltimore,	pemit. Per Department important: any injury once.		21. Signature of Juneral Service Licensee	16.114	HA. Svi	IGHT FUI kesville	NERAL HOM e, MD 2178	E & CHAL	PEL, PA	(Box	: 195)
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	within 24 hours effar death, within 24 hours effar death. To the Funeral Director: A completely fillad in by tha fu	edicai (29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: Cartifying Physician (Check only one)	: To the best of my knowl on the basis of examination	ledge, death on and/or inve	occurred at the testigation, in my	time, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and r date and place	nanner as e, and due	stated. to the cause(s)
	within 2 To the comple	Med	29b. Signature and title of certifier	11		29c. Licen	nse number	10	29d, Date sign	ned (Monti	h, Day, Year)
V	\$ ≠ 8		Vallen Rec	lles m	0		5474	17	4000	12	9 200/
	1		30. Name, and address of person who comple	ted cause death (Item 2	23a) (Type, 6	infit)	1 1	1 -	Sp		
	1		Allen Reilly M	0 801/2	ellet	rseA	re, 0-1	, the	beric	KI	n, oay, real) of 2007
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	Ire Aca	N. 8					

DHMH 16 Rev 6/95

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15.	Physici	an	Togotha.											3. Time of Death			
	/Medic	al	4a. Facility Name (If not institution, g	Claire Luc	as Re	scher	4b. Cit	/. Town, or	Location of	Death	April	24, 20	07 of Death	11:20pm M			
7	Examir	ei	-	Nursing Ho				ckvil			Montgomer						
ľ	Funeral Director		5. Social Security Number 6. 077-12-8819	Sex 7. Ag 1 ☐ M 2 🏋 F	e (In yrs. li 87	last birthday) Yrs.	If Und Months	er 1 Year Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day ovember	Year)		nplace (State or Foreign untry)			
	D		Usual Residence of Decedent							174	Ovember	14, 1919		Hungary			
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	ath wit 5 23a o iust be	ralD	12255 Til	denwood Dr					20852					States			
936	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	-			edent of H ecify Cuba 2∏ No		in? (Speci Puerto Ri	ify Yes or No- ican, etc.)	Specif	ck, White	ican Indian, e, etc. White			
21215-0036	ithin 72 ho ie. ian "natur ian Gedical E	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or leading)	5+)	16a. Dece (Give life.	kind of w DO NOT	rork done o use retired	durina most d		,	16b. Kind of B	usiness/l	ndustry			
	filed w Hygier ther th		17. Father's Name (First, Middle, La.	1							First, Middle,	Phys Maiden Surnar		ns Office			
/lan	uld be Aental rked o tic eve	To Be		artin Luca	s						Kat	y Landl	.er				
Maryland	12 should be filed v n and Mental Hygie 7 Is marked other t raumatic event, th		19a. Informant's Name/Relationship	, , ,								ber, City or Town, State, Zip Code)					
	Health tem 27 other tr		Barbara R. Per	ry/ Daught	20h P	lace of Diene	seition /N	ame of	- 1)rive pril		ille, M		and 20852 Town, State			
imo	Pages ment of I ant: If ite		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		Gar	emetery, cred den of Memor	'ial	Park	11100	20	007	Clarksl	ourg	, Maryland			
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral l Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805										neral Home/ Avenue				
j.	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lither ly one cause on each line. Approximate Interval Betwee														
			Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):														
b			Sequentially list conditions.														
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):													
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O. Box (The law requires that the death certificate be executed te has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	Ideath 3[⊒Ectopic ⊒ Other (pregnancy specify)	,				ate of deli onth	very Day Year			
s, P.O	ires that the de signed by the be detached	by Ph	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the u	nderlying	cause giv	en in Part I.		23e. Did to	bacco use con	tribute to	the cause of death?			
ord	w require been sign	ted t									1 🗆 Y	es 2 No	3 🗌 Pro	obably 4 🖾 Unknown			
or Vital Records,		Completed	-			au pe				24a. Was a autop: perfor	med?	Were au prior to death?	topsy findings available completion of cause of				
Vit.	Physiclan: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	ent 2□	ER/Outpatie	nt 3□.	OOA Oth	or:		Check only or	ne) ence 6 □OtI	her (Sne	rifu)			
	ng Ph fter th ineral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Inju (Month, Da	ıry	28b. Time o		28c. Injur Wor		28		ow injury occur					
Division	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory building, etc. (Specify)							28	f. Location (S City or Tow		ber or Ru	ral Route Number,			
	he Hospi in 24 hour he Funer: pletely fille	Medical (29a. Certifier 1 Certifying (Check only one)	Physician: To the best aminer: On the basis of and manner st	of examinat	wledge, deal tion and/or in	th occurre	ed at the tir on, in my o	me, date and opinion, deat	place, ar h occurre	nd due to the d d at the time,	cause(s) and m date and place,	anner as , and due	stated. to the cause(s)			
	Within Control	Ž	29b. Signature and title of certifier	P. O.			2	9c. Licens	1		2	29d. Date signe	ed (Month	h, Day, Year)			
	d	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								, 2007							
	U		Mina Fazli, MD,	18111 Princ	e Ph	illip		e, #1	01, 0	lney,	, Maryl	and 208	333				
92	Sta Regist		31. Date filed (Month, Day, Year).	07 AZ. Regist	rar's Signa	ture	the										

DHMH 17 Rev 1/2001

To the Fun completely within 2 To the 2 Registrar

Baltimore Bird. WM-MD 21157 VARWALA MD 1130 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Demyer!

29b. Signature and title of certifier

State

29c. License number

D23 L143

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** OS A aways Pr. 120 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Northwest Hospital Center Randallstown Baltimore if Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1⊠M 2□F Yrs 79 Sept. 23, MD Director 219-22-4604 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show 1 ☐ Yes 2 No notified Baltimore Directo Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If flew 27.5 is marked other than "natural", or items 23a or amount yinjury or other traumatic event, the Medical Examiner must be a 110 West Gate Way U.S.A. 21136 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1946–48 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Certified Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward A. Riehl, Sr. Marie E. Ludwig P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmela Riehl Wife 110 West Gate Way, Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Garrison Forest Vets. 5-3-07 Owings Mills MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician as resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner sician and bunial-transit the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician the double Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Day 4 □ Pregnant at time of death 5 ☐ Other (specify) page 2 should be detached ☐ Yes 2☐ No 9☐ Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 4 Onknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certification: (Month, Day 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funerai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 24 and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ham

2007

31. Date filed (Month, Day, Year)

MAY 01

2. Registrar's Signature

			State of Maryland / Department / Department / Department / Department / Department / Department		lental Hy	giene	1000				
16 m				rtificate of Death	Reg. No. C U U /						
2	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day Year	3. Time of Death				
	/Medic		Helen Elizabeth Surman 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	April 2	29 , 2007 4c. County of Dea	<u> 6:15 am</u>				
	LAGIIIII	GI Pig	Ivy Hall Geriatric Center	Middle River		Baltimor	e				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Day	h 9 Bir	thplace (State or Foreign ountry)				
	Director	11-11	214-22-1229 1 M 2 M F 81 Yrs.		12/12/1		rginia				
	land ow it		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits				
	Mary a-f sh ified	tor	Maryland Baltimore Essex				1 □Yes 2X No				
	th the or 28a e noti	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?				
	ath w		4 Capri Drive	21221		U. S. A.					
	er de	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14. Race - Ame Black, Whi					
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify:	hite				
ğ	d within 72 hours after death with the Maryland glene. Jene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	ted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation			b. Kind of Business/Industry				
2	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of worki DO NOT use retired)	ng						
7		S	2 Supe	rvisor	/Fin-4 Adiabath	Civil Defe	nce				
Maryland 21215-0036	0 1 1 D	Be c		İ		Maiden Surname)					
	d 2 should be th and Mental 7 is marked o traumatic eve	ပ္	Charles Holland Richardson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailli	Loma Cr ng Address (Street and Number or Rura	rawford al Route Numbe	er, City or Town, State.	Zip Code)				
	C1 C E					land 21085	•				
Jre,	ーエッキ		20a. Method of Disposition 20b. Place of Dispo	sition (Name of	Date	20c. Location - City or					
altimore,		ı,	1 ZABuriai 2 Cremation 3 Removal from State	11 Memorial Garden	:007 IS	Middle Riv	er, Maryland				
Bait	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	2. Name and Address of Facility ruzdzinski Funeral	Home F	PA					
	<u>0</u> 0 = €0		Eichard & Jaffras Sr.	<u>407 Old Eastern Av</u>	renue E	Essex, Mary					
			23a. Part1. Enter the disease, are implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final								
	Physician /Medical		disease or condition resulting in death) a. Comany (1884) Colo Swed								
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7	F. Hillion	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			6					
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Box	The law requires that the death certific the has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of de	livery				
	death e atte	icia	in the past 12 months? 1	Ectopic pregnancy Other (specify)		Month					
о. О	at the by th	hys	9 □Unknown								
	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown					
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Vital Records,	sician: The law certificate has t irector, page 2 s	Completed	typertension		24a. Was autop		utopsy findings available completion of cause of				
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000	endin sath. or: Af he fur	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No							
Division or	or Att fler de direct n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,				
	pital ours a eral D		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place	and due to the	nauco(s) and mannor a	a stated				
	To the Hospital or Attending Physician: within 43 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, r	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time,	date and place, and du	e to the cause(s)				
	To the within To the Comp	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon					
	0		→ HOL D.O.	43559	5	April.	30,2007				
_	6		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	h	, / 6 .5	30,2007				
)		31. Date filed (Month, Day, Year) 32 Registrar's Signature	mace the,	150	DO. M	2.21221				
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, ITEM 250 h Lo La La La La La La La La La La La La La	de							
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. amend 11em 9 per 1h 9867 5-1-07 vt. State of Maryland Department of Health and Mental Hygiene, 100 per 11 per 11 per 12 per 13 per 14 per 15 pe Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 15 pm TARRIETT SHIPLE 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) If Under 1 Year If Under 24 Hrs. 8. Date of F FREDERIC DRSING PEHAB CELITER

7. Age (In yrs. lest birthday) If Und VAI Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 1 M 2 X F a 2 | 4-76-15| Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD 1 Tyes 2 No Frederick Walkersville Director 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 56 Frederick Street, W. 21793 Funerai USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Hamilton Greenberry Simpson Ida Irene Hungerford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mrs. Charlotte Dulany (Daughter) 397 Bear Branch Road Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Memorial Park 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/28/07 Sykesville, MD 22 Name and Address of Facility HOME & CHAPEL, PA (Box 195) 21. Signature of Funeral Service Licenses Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Te myo Corvia

Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 🔭 No 3 Probably 4 Unknown Š 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? **3**√2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 □ Yes 2 □ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

inding physician end use as the buriel-trensit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ed by the a deteched f been signed to should be det page 2 s After this within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral To the Hospital

Be

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Certification:

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumetic event, the Madical Examiner must be inclined at

njury or

Physician

/Medical

Examiner

10

State Registrar

Thomas 31. Dete filed (Month, Day, Year)

29b. Signature end title of certifier

30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Thorson Registrer's Signature

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Yeer)

Hiren

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** 17:45 ut 4 one tte Singletor 3 7007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 0 mare 0 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth Month, Day, 5. Social Security Jumber Birthplace (State or Foreign Country) **Funeral** 1 M 2 V arolina Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 Ves 2 No Director ma 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritai Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 ax 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the Pages 1 and 2 should be filed vinent of Health and Mental Hygie int: If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City, or Joyn, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau he vard 35 20a. Method of Disposition mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State BarField Cemetery May 1, S. Carolina 2007 Alcol Other (Specify) 4 □ Donation 21. Signature of run eral Service Licens 22. Name and Address of Facility Fred HIL any ir neval Home Pimarch Baeto, md, 21229 23a. Party Ener t Ausease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of hart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C == e (Final disease or condition resulting in death) utrucerebral 6 looch **Physician** Stroke dung /Medical (or as a consequence of) Examiner vuknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner that the death certificate be executed Due to (or as a consequence of) physician as the burial-1 Box 68760, Physician/Medical as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9□Unknown 9 Unknown þ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Abo 24a Was an certificate has birector, page 2 si autopsy perform 1□ Yes Division or Vital 2 1 the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 22 1 patient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation Injury thin 24 hours arter control of the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier i 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) (ubaklur. 2

State Registrar 31. Date filed (Month, Day,

827

MD

32. Registrar's Signature

Aug.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year!

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1135 AM Schuster 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltmine, MD Baltimore VA Hospital. N/A 10 N. Greene St. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. Feb 9, 1949 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 58 025-36-3444 Massachusetts Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other freumatic event, the Madical Examinat must be nufficed at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Aberdeen Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 70 Norman Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1967 If Yes, Give Year or Dates: 1971 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Schuster Janetta Revnolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Schuster, Wife 70 Norman Avenue Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 04/28/07 Baltimore, Maryland 21. Signature of Funeral Service Licenses
Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sep sis /Medical Due to (or as a consequence of): **Examiner** aspiration meumoria 3 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ģ Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Diabetes mellitu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown renal failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No 27 No 1 Tyes 1 Yes Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1XInpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pendina 1 Yes 2 No investigation death. Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 27/07 (Christma Sennett) AU4176435 BITSI 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Green St. Baltimore State Registrar

			For	f Maryland		rtment of F		and Me	, ,				
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Sie masho, Lawrence.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh may Injury or other traumatic event, the Medical Examiner must be notified once.		20a. Method of Disposition	20b. P		sition (Name of matory or other place		Dat		20c. Location -			
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			Dr. David Hager 9000	Frankli	in Squ	Print)	re Bo	altin	nore, 1	11 212	37		
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1	5	i	30. Name and address of person	who completed cau	ise of death (Iter	23a) (Type	Print) Rave	en /s	Iva	0,180	Mine	re,	no	7	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17, 18 per fb 9867, 5-1-07, vt. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** рΜ Smith April 27 2007 8:55 Joan /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🛛 F Months Days Hours Min Director 059-26-8866 July 30, 1933 73 New York Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show t be notified at 10a State 10h. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a c any injury or other traumatic event, the Medical Examiner must be once. Funeral 703 Chapel Ridge Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Homemaker Own_Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ James Gerin Curin Johanna **Herlihy** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Chapel Ridge Road, Timonium, MD of Disposition (Name of Date UNE 20c. Location Mr. John Smith/Husband 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Hawthorne, New York 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 bryan W. Clary 23a. Part1. En/ r the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Chuse (Fin I disease or condition resulting in dea **Physician** Amvotrophic /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending P nours after death. neral Director: After the filled in by the funer. 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dynthia Smicew No D0051347 4/28/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Soriano MD 6701 N. Charles St. Baltimore MD 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAY 0 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) William George Sherman Jr. pril 25 5, 2007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min. 1**V**□M 2□F 218-38-3713 64 Yrs. May 9, 1942 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Carrol1 Sykesville MD 1 ☐ Yes 2 ☐ XNo 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21784 USA 2014 Red River Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) auto glass installer automotive 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rita Alfinito William G. Sherman Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nancy Sherman (spouse) 2014 Red River Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Svkesville, MD 4-30-07 Lake View Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daige Haught Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOMYOPATHY disease or condition resulting in death) DISEASE CORONARY Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If ves. outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OF THE URINARY BLADDER 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown RADICAL CYSTOPROSTATECTOMY 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural

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Examine Physician/Medical 9 Completed

Certification:

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun

Physician

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Examiner

death

within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

1 Yes 2 No

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

4 ☐ Homicide

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

A.J. Helon, M.D.

29c. License number
29d. Date signed (Month, Day, Year)
29d. Date signed (Month, Day, Year)
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDALLAH J. HELOU, M.D.

CARROLL HOSPITAL CENTER WESTMINSTER MD 21157

State Registrar 31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

To the Hospital or At within 24 hours after d

filled in by

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year Richard Kenda11 28, Scott Apri1 2007 8:00p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1089 Dicus Mill Road Millersville Anne Arundel 8. Date of Birth (Month, Day, Yes If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1922 Days Hours 1X M 2∏ F 250-12-1686 84 SC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Anne Arundel Millersville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21108 U.S.A. 1089 Dicus Mill Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fertilizing Plant Supervisor 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eunice Hodge ဂ Pink Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 275 Pinewood Road Millersville MD 21108 Mrs. Judy Rhodes/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Cedar Hill Cemetery Brooklyn Park, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature / Fur er | Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. Second Avenue SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mestice Due to (or as a on equence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 5. Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c 28d. Describe how injury occurred 1-Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Box 68760, P.O. or Vital Records,

The law requires that the death certificate be executed physician and s the burial-trans attending pl for use as t ed by the a signed t peen rector, page 2 s funeral director, After this after death.

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Physician

/Medical

Examiner

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

þ Completed Be 2 Certification:

Medical 0

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

6 Could not be

29b. Signature and title of certified

1/1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death_(Item 23a) (Type, Print) HID Ritchio 8109 IURI

and manner stated

31. Date filed (Month, Day, State Registrar

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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State Registrar

MAY 0 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Month April Physician 27, 1:55 P. M Francis Arthur Shaw /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Silver Spring 3345 South Leisure World Blvd. Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye. Dec. 10, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months New York 1 MM 2 □ F 057-24-6486 77 Dec. 1929 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🖾 No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3345 South Leisure World Blvd. 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Korea Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inspector Utilities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Shaw Alice Gonyea 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trauonce. 1489 Birchcrest Ln., Charlottesville, VA 22911 Michael F. Shaw / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pate May 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 Donation 5 Dother (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service Lionsee Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction 10 minutes /Medical Due to (or as a consequence of): Examiner 25 years Ischemic Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed the burial-tran Due to (or as a consequence of) the attending physician Physician/Medical as 1 IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 2₩ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 AResidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ² 1 ∰ Yes 2 □ No After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Ae Hospital or Au.

* hours after death.

* al Director; After

* by the fur 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C 29a, Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 tuen D20400 April 30, 2007

3altimore, Maryland 21215-0036

Box 68760

P.0.

Division or Vital Records,

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Mark Rosen, M.D., 3941 Ferrara Dr., Wheaton, Maryland 20906

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 23 04 30 Gerald Toomey 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2918 Vermont Ave. <u>Baltimore Highlands</u> Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year Sept. 21, 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Year) Months 1 M M 2 □ F 65 Sept. 1941 Maryland Director 217-38-2149 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County 'natural', or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Baltimore Highlands 10e, Street and Number 10f. Zip Code 10g Citizen of What Country? 2918 Vermont Ave. 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner once. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 Specify. White Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Town Motor Operator Gas Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sylvester C. Toomey Josephine G. Seebach ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2918 Vermont Ave. Dawn Meyer, daughter Baltimore, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Nurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery 04-30-07 Baltimore, MD 21. Signature of Tyneral Service License 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

2719 Hammonds Ferry Rd. Lansdowne, MD. 21227

Approximate interval Between onset and Death one of the course (Fine). Immediate Cause (Final disease or condition resulting in death) Physician Coronary artery disease

Due to (or as a correquence of): ears /Medical Examiner Hypertension busto (or as a consequence of) Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner physician and s the burial-trans Due to (or as a consequence of): ivision or Vital Records, P.O. Box 68760 for use as IF FFMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by congestive heart failure cancer 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No abuse 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 0 Hospital

State

29a. Certifier

(Check only

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO.

Smith,

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Medical

1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2. 4000 Annapolis Road, Bathmore, MD
32. Registrar's Signature

29c. License number

D0060088

29d. Date signed (Month, Day, Year)

04/27/2007

07-03129 Crystal C. Telp Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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¥	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)		er 1 Year	If Under 24		of Birth(MI	M/DD/YYYY	9. Birt Foreig	nplace (State or	
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Ī	Funeral Director		5. Social Security Number 6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday, Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min. 2 29	(Month, Day, Yea	ar) 9. Birthpli 007 MD	ace (State or Foreign try)
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Baltimore,	Pages 1: nent of He ant: If iten ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	Springfi	osition (Name of matory or other place) eld Cemetery 4-28	S-07 Sy	Location - City or Tov kesville,	MD
Balt	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licensee	usert 2º	2. Name and Address of Facility Ha .0. Box 195 Sykes	ight Funer ville, MD	al Home & 21784	Chape1
	Physician		23a. Part1. Enter the disease, or complications tha shock, or heart failure. List only one cause of immediate Cause (Final disease or condition	t caused the death. Do not en n each line.	ter the mode of dying, such as cardia	or respiratory arrest,		Approximate Interval Between Onset and Death
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8760,	cate be executed physician and the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	o (or as a consequence of):				
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		ledical	(Check only 2 Medical Examiner: On the one) and m	the best of my knowledge, deat basis of examination and/or in anner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	rred at the time, date a	and place, and due to	the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 21 Month Year **Physician** Vasquez 2245 2007 Jorge tpril /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore Hopkins 16. Sex Johns Mosn If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 61 Peru Director 216-51-6624 1946 Jan. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☐ No Directo MD **Baltimore** Cockeysville 10e. Street and Number 10g. Citizen of What Country? ms 23a or 7 r must be n 10117 Daventry Dr. 21030 Peru Funeral ural", or items 2 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∏ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or V☐Yes 2☐ No þ Specify: Hispanic 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Secondary (0-12) College (1-4or 5+) Pharmaceutical Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pascual Vasquez Manuela Bardales မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha G. Baca/wife 10117 Daventry Dr., Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Metro Crematory 4/27/07 Catonsville, MD Signature of Inner Service Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. Lowell M. Lemmon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) 36 hours /Medical Due to (or as a consequence of): **Examiner** 9 months Bilateral Due to (or as a consequence f) Transplant Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Pulmonary Fibrosis years Idiopathic sician and burial-trans Due to (or as a consequence of): attending physician for use as the buna Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 ☐ Yes 2□No 1∐ Yes 2X No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☑ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a

To the Funeral I

completely filled

Saltimore, Maryland 21215-0036

State Registra

29b. Signature and title of certifier

31. Date filed (Month

MD

600

NORTH

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ITTON

WOLFE

29c. License number

RES-000

STREET, BALTIMORE, MARYLAND

29d. Date signed (Month, Day, Year)

April 24, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2007 April **Physician** 30, 8:20A ROSA ETELVINA VILLACRES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | Min. | March 19, 1916 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1□ M 2√X 91 Ecuador 219-62-3826 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1√XYes 2□No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21210 USA 5514 North Charles Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examines 1 ☐ Never Married 2 ☐ Married 1 □ Yes XX No White þ Specify: 3 ☐ Widowed 4 X Xivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Seamstress Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carmella Ron Donato Bianculli ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5514 North Charles Street Baltimore, Maryland 21210 Grace V Chambers Dtr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 5/2/07 Parkville, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. gnature of Funeral Se vice License 6500 York Road Baltimore, Maryland 21212 NNUS 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Immediate Cause (Final **Physician** weeks resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☑ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

law requires that the death certificate be executed Box Records, P. Division or Vital Hospital or Attending Physician: To the Hospital within 24 hours a To the Funeral E

death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated.

30. Name and address of person who commeted cause of death (Imm 23a) (Type, Print)

2007

29c. License number

GXIN-Chales S. Batto. Md Z. 204

Division or Vital Records, P.O. Box 68760,

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Boritz, The

DHMH 17 Rev 1/2001

Johns Hopkins Hospital 32. Registrar's Signature

Melical Doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Res - 000

600 North Wolfe Street, Baltimore.

29d. Date signed (Month, Day, Year)

25,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, 3. Time of Death 25 **Physician** 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City, Town, or Location of Death Examiner N Greneral Year If Under 24 Hrs. 8 Date of Birth
Davs Hours Min. (Month, Day, Year) If Under 1 6. Sex Birthplace (State or Foreign Country) (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗗 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Ħ 1 Yes 2 No ıral", or items 23a or 28a-f sl | Examiner must be notified Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 2 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Socondary (0-12) Gollege (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be rancis a ္ပ al 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) 212 Department of Health Important: If item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State injury or 30 4 ☐ Donation / Dother (Specify) 21. Signature 🖈 uneral Service Licens any Bacto. md, 21229 23a. Part1. Et a the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence offlaw requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 □Ectopic pregnancy for Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ 1 | Yes 2 | No 3 | Probably 4 DUnknown Completed been a 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perform To the Funeral Director: After this certificate completely filled in by the funeral director, pag 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No Hospital: 1 ☐ Yes 12 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wriame

Year)

32.

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

07-03201
Gregory Walker

03201 egory Walk	Please Type	or Print in Black In e of Maryland / Depa	delible Ink. Ensure Artment of Health and N	All Copies Are L Mental Hygiene	_egible.	200	7 1394	
	1- For State Registrar	Cer	tificate of Death		Reg. No.			
Physi I Exa				2. Date of I Month April 26	Day 0, 2007	Year	3. Time of Death 1849 hrs	
	4a. Facility Name (if not institution, 3107 Ravenwood Avenu		4b. City, Town, or Loc Baltimore		N	unty of Death		
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Physicia		1. Decedent's Nam	e (First, Midd	le,Last)								Date of De			3. Time of Death
l Exami	ner	Gregory A	A. Wall	ker								Month April 26,	Day Yea 2007	ir i	1849 hrs
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		3107 Raver	nwood Ave	enue				Baltim	nore				N/A		
Funeral		5. Social Security	Number	6. Sex	7. Ag	e (In yrs. la	ast birthday)	If Unde	r 1 Year	If Under	24Hrs. 8	B. Date of E	hirth (MM/DD/YYYY		
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Page ment tant:		4 Donation 5				Me	tro Cr				5/1/	07	Baltim	ore,	MD
Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr		21. Signature of Fi	uneral Service	Licensee	C. Todo	d Dri	ng C	Name and	ion	Socie	etv o	f Mar	vland. I	nc.	
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Examiner		Immediate Cause or condition result					ascular Di	sease							Death
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Division or A hours after uneral Directly filled in by	Certification:	4 Homicide	det		Specify)							OI TOWN	, otate)		
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the the	<u>:</u>	one) 2 🗸	Medical Ex	aminer:On th	e basis of exa	amination a	and/or investig	gation, in m	y opinior	n, death occ	curred at t	he time, da	te and place, and	due to th	ne cause(s)

29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number April 27, 2007 O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)
Susan Hogan MD. Assistant Medical Examiner 1

111 Penn Street, Baltimore, MD 21201

State 31. Date filed (Mooth, Registrar

			Stat		/ Department	of Health and I	-	_	10011
			For State Registrar		Certificate	of Death		. No.	10944
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) A Y U 4a. Facility Name of not institution, give street an	lepsk		own, of Location of Deat	2. Date of Death	Pay Year ZOO	3. Time of Death
7.5	Examin	er	LOVICH Warfing	//	C	dumsia	7	How	ac of
	Funeral Director		5. Social Security Number 216-34-8880 Usual Residence of Decedent	7. Age (In yrs. las	st birthday) If Under 1 Yrs. Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,) Jul. 3,		nplace (State or Foreign untry) ryland
	death with the Maryland ms 23a or 28a-f ehow rmust ke notified at	tor	10a. State 10b. County 10b. Baltimore		Town or Location Catons	ville			10d. Inside City Limits 1 ☐ Yes 2 XNo
	or 28a	Funeral Director	10e. Street and Number	4	10f. Zip (. Citizen of What Co	
	eath w	erai	715 Maiden Choice Lane	Decedent Ever in U.S.		21228		nited Sta	
	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. and Mental Hygiene. Is marked other then "natural", or items 23a or 28a-f ehow aumatic event, the Medical Examinat must be notified at	by	1 Never Married 2 Married 1 If Ye	ed Forces? Yes 2 📉 No is, Give r or Dates:	If Yes, specification of the Yes 2	ent of Hispanic Origin? (S fy Cuban, Mexican, Puert No Specify:	o Rican, etc.)	Black, White	hite
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Maryland 21215-0036	be file	Be	17. Father's Name (First, Middle, Last)				me (First, Middle, Ma	iden Sumame)	
	should ind Men marke umatic	P	John Dettler 19a. Informant's Name/Relationship (Type, Prin	t)	19b. Mailing Address	Street and Number or Ru	n Ashby ural Route Number, (City or Town, State, 2	Tip Code) 21228
	and 2 : ealth ar n 27 is		Alfred E. Wielepski	Husband	715 Maiden	Choice Ln,	Apt. CC21	2, Catons	ville, MD
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke eny injury or other traumatic.		20a. Method of Disposition X Burial 2 Cremation 3 Removal	from State Mead	ice of Disposition (Name metery, crematory or oth OWTIDE MET	her place)		c. Location - City or	
altin	permit. Pa Departme Important eny injury once.		4 Donation 5 Other (Specify) 21. Signature of Europe Service Licensee	7	Park 22. Name and	Address of Facility An	brose Fur	lkridge, eral Home	· Inc.
<u>~</u>	Depa Impo Impo eny ir		off elevely		2/19 Ha	anmonds reri	ry ka., La	nsdowne,	MD 21227
	Physician /Medical		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	that caused the death. on each line. ue to (or as a conseque	Do not enter the mode	of dying, such as cardial	c or respiratory arres	t,	Approximate Interval Between Onset and Death
7	Examiner	ler	Sequentially list conditions.	ue to (or as a conseque	ence of):	1301			(Oyen
760, 14	ie be executed ysicien and e burial-transit	cai Examiner	trial initiated events	ue to (or as a conseque	ance of):				
687	0 % 0		d						
O. Box	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	in the past 12 months?	es, outcome of pregnan Live birth 2 ☐ Fetal o Pregnant at time of dea Unknown	death 3 Ectopic pre			23d. Date of del Month	ivery Day Year
ds, P.O.	uires that the de signed by the a lid be detached f	by	Part II. Dther significant conditions contribution	g to death but not resul	ting in the underlying ca	use given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Reco	The law rec	Completed					24a. Was an autopsy perform	prior to death?	itopsy findings available completion of cause of
/ita	cian: ertifica ector, p	Be	25. Was case referred to medical examiner?				ath (Check only one,	, ,	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires the minim 24 hours after death. To this certificate has been signed to the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de	tion: To	1 Yes 2 No Hospital: 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 E	RVOutpatient 3 DO/ 28b. Time of Injury M	A Other: 4 Nursing Hack Injury at Work? 1 Yes 2 No	dome 5 Residen	ce 6 ☐Other (Spe rinjury occurred	cify)
Divisi	al or Atter s after dea il Director od in by the	Certification:	3 Suicide 6 Could not be 28e.	Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory,	office	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	e Hospital 24 hours a E Funeral i letely filled	edical (29a. Certifier (Check only one) 12 Certifying Physician: 2 Medical Examiner: On and						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	min	290.	License number	29	d. Date signed (Mont	h, Day, Year)
14.	0		· Villy		1	19161,	1 /	pr Z	1,2007
	17		30. Name and address of derson who completes	d cause of death (Item)	23a) (Type, Print)	Je RdC	Olymsi	& Ma	121049
		1	31. Date-filed (Month, Day, Year)						

07-03128 George Will Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

orge will		1- For State Ce.	artment of Health and Mental H rtificate of Death		. No.	1 1394
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
edical Exami		George Earl Will		Month April 23, 20	07	1829 hrs
MA		Facility Name (if not institution, give street and number) Bon Secours Hospital	4b. City, Town, or Location of Death Baltimore	1	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.			(MM/DD/YYYY) 9. Birt Foreig	nplace (State or
Director		214-86-6055 _{1xm 2} 44	Yrs. Months Days Hours Min	Jan 28.		untry) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Location			10d. Inside City Limits
and show nce.	5		imore			1 X Yes 2 No
Maryl: r 28a-f	Director	10e. Street and Number 306 South Furrow Street	10f. Zip Code 21223	100	g. Citizen of What Cour $\mathrm{U.S.A.}$	itry?
s, MD 21215-0036 and 2 should be little within 72 hours after death with the Maryland tealth and Mental Higele. tealth and Mental Higele. tean 27 is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Was Decedent of Hispanic Origin? (S		14. Race - Ameri	can Indian, Black,
death or item	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	White, etc.	
rs after ural",		3 XWidowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 X No specify:	work done	Specify: Whit 16b. Kind of Business/I	
72 hour	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret			
0036 within iene. ier tha	Jung	11	Machine Operator	e (First, Middle, M	Bindery	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, Last) George Edward Will	Ann Feel		alderi Surname)	
212 nould b id Men is marl tic eve	일	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or			, Zip Code)
, MD and 2 sho calth and em 27 is		Mary Will/Sister 20a. Method of Disposition 20b.	310 Furrow Street Bal	Date	1D Z1ZZ3 20c. Location - City or	Town, State
Baltimore, MD 21215-0036 pennit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiewich Important: If tiem 27 is marked other than "natural", injury or other traumatic event, the Medical Examine:		1 Burial 2 X Cremation 3 Removal from State	crematory or other place) st Arundel Crematory 04-	28-2007	Odenton, 1	Maryland
altin mit. Pa partmet portan ury or		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	22. Name and Address of Facility Am		neral Home	of Lansdown
		23a. Fart I. Enter the disease, or complications that caused the death	2719 Hammonds Fern			21227 Approximate Interval
Physician /Medical		failure. List only one cause on each line.	clerotic Cardiovascular Disease	or respiratory arres	ot, shook, or heart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a Hypertensive Atherosc Due to (or as a consequence or condition resulting in death)				
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	of):			
a)	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	of):			-
and transit		d. ·				
60, ate be ex hysician e burial	Medical	UNPENDED AMENDED			23d. Date of deliver	<u> </u>
tox 68760, eath certificate be estatending physicia for use as the buria	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre	2 Fetal death 3 Ectopic pregn	nancy	1	Day Year
Box 687: death certific the attending ped for use as the	Physician/	1 Yes 2 No 9 Unknown g Unknown	Geath 5 Other (Specify)	_		
O. E hat the ded by the etached	by Ph	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.		pacco use contribute to	
Is, P.C quires that en signed t				1 Yes 1 24a. Was a		oably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requir is after death. Director: After this certificate has been is led in by the funeral director, page 2 should!	Completed			autops perform	prior to oned? prior to one death?	completion of cause of
tal Rection: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 k only one)	No 1 Ye	es 2 No
Vita tysicia this cer	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓	ER/Outpatient 3 DOA Other Nurs	ing Home 5 F	Residence 6 Othe	r:
n of ding Pl After funeral	Ë	27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
isior Attender death	icati	2 Accident Investigation 28e. Place of Injury - At	home, farm, street, factory, office building, etc.	28f. Location (S	treet and Number or Ru	ural Route Number, City
Divis pital or At ours after d teral Direc filled in by	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, St	ate)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transit		29a. Certifier 1 Certifying Physician: To the best of my knowle one) 2 Medical Examiner: On the basis of examination	edge, death occurred at the time, date and place, an and/or investigation, in my opinion, death occurred	nd due to the cause at the time, date a	e(s) and manner as state	ed. ie cause(s)
To t To 1	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	
		(arol Holla	O.C.M.E.		April 26, 2007	
\		30. Name and address of person who completed cause of death (Ite	m 23a) 111 Penn Street, Baltimore, MD 212	 01		
	State	Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signa		01		
Regis			J.J. Salation Co.			

			1 - For State Registrar	State of Mary		artment <i>rtificate</i>			Mental H	ygiene	007	13943
	Physic /Medi		1. Decedent's Name (First, Middle, Last,)		WILLI	A-MS	5, Jr	2. Date of D Month		Year 2007	3. Time of Death
· **	Exami		4a. Facility Name (If not institution, give	S HOSPITAL		4b. City, T	own, or L	ocation of Deat	h T Y		unty of Death	
	Funeral Director		5. Social Security Number 6. Set 216-86-0789 X	7. Age (In	yrs. last birthday, Yrs.		Days	If Under 24 Hrs Hours Min.	8. Date of B (Month, D	lirth Da <i>y, Year)</i> L 197	Cour	place (State or Foreign ntry) MD
	the Maryland	Director	10a. State 10b. County NA		:City,Town orLo	re						1 M Yes 2 No
-0036	n 72 hours after death with the Maryland "natural", or Itema 23a or 28a-f show willical Examinar must be notified at	by Funeral	10e. Street and Number 3000 E. Fayett 11. Marital Status XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decede	224 ent of Hisp by Cuban,	Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	U S	A Race - Americ Black, White, ecify: Bla	ean Indian, etc.
Maryland 21215-0036	il Hygiene. other than	e Completed	(Specify only highest grade Elementary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, Last)	College (1-4or 5+) NA	(Give	kind of work DO NOT use	retired)	ring most of wo	rking NA			NA
	s 1 and 2 should be f Health and Mental Item 27 le marked c other traumatic eve	ToB	Frank Williams. 19a. Informant's Name/Relationship (Ty. Frank Williams	pe, Print)	19b. Mailio	ng Address (Thorr	Street an	d Number or Ru	e Rhoc ural Route Numi d Balt	ber. City or To	wn, <i>State, Zip</i>	(Code)
Baltimore,	Page ent o nt: If ry or		20a. Method of Disposition 1 X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21 Signatule of Funeral Service License	emoval from State	b. Place of Dispo cemetery, crei King Me	sition (Name natory or oth MOria	e of ler place) al P	k 5-2	Date - 2007	20c. Location	on · City or To	
Ba	permit. I Departm Importar any injus		23a. Part . Enter the disease, or complishopk, or hear failure. List only or	Uhlter	h/	1101	Ε.	North	arch F Avenu	e Bal	ast to, MI	D 21202 Approximate
	Physician /Medical Examiner		Immediate Cause (Final dispass or condition resulting in death)	NFECTI Due to (or as a con	VE EN	DOCAR	LDIT	15				Interval Between Onset and Death
8760,	cate be executed by sicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):			1		614		o tears
P.O. Box 6	The law requires that the death certificate be executed ate hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pred					Date of delive Month	ry Day Year
ords, P	w requires that been signed the should be detentioned to the should be det	ted by P	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cau	ise given	in Part I.		tobacco use c Yes 2 X No		e cause of death?
al Rec	ician: The law r certificate hes be rector, page 2 sh	e Completed	OF West and the second						1 ☐ Yes	ormed? 2 No	prior to con death?	osy findings available inpletion of cause of 2 No
Division of Vital Records,	ding Phys h. After this funeral di	To B	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of Injury		Other: c. Injury at Work?	4 Nursing H	ome 5 Res 28d. Describe	idence 6 🗆 (')
Divis	tal or Atters after desail Director	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spi	t home, farm, streecify)	et, factory,	office		28f. Location (City or To	(Street and Nu wn, State)	mber or Rurai	Route Number,
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	Medical	one)	ician: To the best of my ler. On the basis of exam and manner stated.	ilaation and/or inv	actionation is	my onin	on death accur	read at the time	data and alas		Ab / - \
)	1 × 5 8		29b. Signature and title of certifier Olcay Alcsoy, (al Doctor	29c. 1	ES -			29d. Date sig	ned (Month, L 6-07	Jay, Year)
<i>J.</i>	Sta		30. Name and address of person who could also also also also also also also also	nns Hopkins 32 Registrar's Si	Hospital	600 N	orth	wolfe St	treet, f	Baltimor	re Ma 21	287
	Registr		MAY 0 1 200	17 10000	S. An	Mes						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 12:30 PM **Physician** Williams 200 owen do lyn April /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Northwest Randallitown Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/05/4 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔽 F 63 212-46-3383 BALTIMORE, LID Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at BALTIMORE 1 Yes 2 No MD Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 3503 ELLAMONT Road 21215 USA Funeral Pages 1 and 2 should be filed within 72 hours after death vient of Heath and Mohald Hyglene.
ant: If item 27 is marked other than "natural", or items 23a mat; If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLEUK Shoppeals 12 GRAJE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BACKERS JESSE Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. uc Fadden 20b. Place of Disposition (Name of cemetery, crematory or other place) Owings Mulls, MD 21117

20c. Docation - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ARbutus 05/03/07 ARbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Yours C. Greare 7 wrongs Services /8723 Liberty Rd.

Randallstown, ND 21133 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Multiple organ system
Due to (or as a consequence of): disease or condition resulting in death) /Medicai Examiner votemic inflammator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Examiner Division or Vital Records, P.O. Box 68760, 76 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after Apair. Metastatic breas cancel Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown Hypertension Osteoarthritis 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Anemia of chronic 24a. Was an autopsy performed? Yes 2 No Osteoporosis
25. Was case referred to medical examiner? this certifica 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Man er of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funera 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)
April 27 200 29b. Signature and title of certifier 29c. License number D28462 Booton MD 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown Northwest Maryland 21133 Boston Hospital Center 31. Date filed (Month, Day, Year) MAY 0 1 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2007

07-03145 Carlton Ward Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Day April 24, 2007 1030 hrs Medical Examiner Ward, Jr. Carlton 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Maryland General Hospital Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Country) N. J. Min Months Days Hours Director 153-50-5252 50 11-28-1956 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County s 23a or 28a-f show e notified at once. 1 X Yes 2 No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 508 West Lafayette Ave. U.S.A. 21217 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status , or items . event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married Married 2 Yes Divorced If Yes, Give Year Yes 2 X No specify. black item 27 is marked other than "natural", ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene ant: If item 27 is marked other than "n College (1-4 or 5+) Baltimore, MD 21215-0036 2 disabled na 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Lawrence Williams Be Christine Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Williams, father 8312 Tinsley Rd., Windsor Mill, Md. 21244 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) or other 1 Burial 2 X Cremation 3 Removal from State 4/28/07 Catonsville, Md. Metro Crematory Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Loring Byers Funeral Directors 8728 Liberty Rd., Randallstown, Md. mmer 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line 'Medical Death Hypertnsive atherosclerotic cardiovascular disease Immediate Cause (Final disease *x*aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last by the attending physician and ached for use as the burial - transit The law requires that the death certificate be executed Physician/Medical X UNPENDED X AMENDED a, PII, 27, perME, 2868, 6/5/07 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Year Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ξ Yes 2 No 3 Probably 4 ✔ Unknown Diabetes mellitus: asthma Completed Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? Yes 2 V No Yes 2 No ... rospital or Attending Physician: The within 24 hours after death.

To the Funeral Director 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Other₄ 2 V ER/Outpatient 3 Nursing Home 5 Residence Inpatient 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. April 25, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Registrar's Signature 31. Date filed (Month.) 1 2007 State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

			Pleas			delible Ink. Ensure artment of Health and		7 1 1 1 1 1	13949
			For State	State of W	-	rtificate of Death		g. No.	
			Registrar 1. Decedent's Name (First, Middle, i	Last)			2. Date of Death		3. Time of Death
	Physici		Helen Babcock W	lieferich			April 2	6, 2007 Year	3:41 AM
7	/Medio Examir		4a. Facility Name (If not institution, g			4b. City, Town, or Location of Dea	ath	4c. County of Death	1
			Holy Cross Hosp	ital		Silver Spring		Montgome	
	Funeral Director		5. Social Security Number 6 3 3 1 - 20 - 2 3 8 4	. Sex 7. Ag 1 ☐ M 2 🖾 F	e (In yrs. last birthday) 96 Yrs.	If Under 1 Year If Under 24 Hi Months Days Hours Min		Year) 9. Birth Col	nplace (State or Foreign untry) Illinois
			Usual Residence of Decedent						
	nylan show	_	10a. State 10b. County		10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f o	Director		gomery	Bet	thesda			
	or 24	Dire	10e. Street and Number			10f. Zip Code		g. Citizen of What Co	-
	ath w		7913 Kentbury Dri			20814		United Sta	
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	Specify Yes of No- erto Rican, etc.)	Black, White	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other than "natural", or Items 23e or 28s-1 ehow other traumatic event, the Medical Exercise mast Le notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2/☑ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☒ No Specify:		Specify: Wh	ite
21215-0036	s hou	ed	15. Decedent's	Education	16a. Dece	dent's Usual Occupation	. 1	6b. Kind of Business/l	ndustry
215	hin 7:	pie	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or)	life	s kind of work done during most of w DO NOT use retired)	rorking		
21	e filed within al Hygiene. I other than 'vent, the Me	Completed		4		Secretary		Lega1	
멀	al Hy d oth	Be (17. Father's Name (First, Middle, La	est)		18. Mother's N	ame (First, Middle, M	aiden Sumame)	
Na N	Ment Ment Prkec	2	John Babcock			Mary	Carter		
Maryland	2 should be and Mental if it is marked or raumatic eve		19a. Informant's Name/Relationship	_		ing Address (Street and Number or			
	1 and 2 Health tem 27	1	Patricia Ross / I	aughter	9905 20b. Place of Disp	Broad Street, Be		Oc. Location - City or	
Baltimore,	Page nent o nt: If ry or		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Montgomery	Crematorium, Inc.	2007 B	ethesda, M	aryland
Balt	permit. Pa Departmen important: eny injury once.		21. Signatory of Funeral Service Li		M01473 B	2. Name and Address of Facility Re ethesda-Chevy Cha ethesda, Maryland	obert A. P ase Inc. 1 20814-35	umphrey Fu 7557 Wisc 01	neral Home/ consin Ave.,
			shock, or heart failure. List or	omplications that cause bly one cause on each l	d the death. Do not en	ter the mode of dying, such as card			Approximate Interval Between Onsef and Death
	Pnysic an	9	Immediate Cause (Final disease or condition resulting in death)	- u	monia				
1	/Medical Examiner		resulting in doubly	1000	a consequence of):				
н		-	Sequentially list conditions,	b. Seps	LS a consequence of):				W.V
	ted nsit	i i	Sequentially list conditions, it any leaving to immediate cause. Enter Underlying Cause (Disease or injury	Asci	tes				
	executed in and ial-transit	Examiner	that initiated events resulting in death) Last	C	a consequence of):				
760,				ď					
9289	ificate g phy as the	ledicai							
č	death certificate be executed e attending physicien and id for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome				23d. Date of del	.,
ω.	death e atte	Cia	in the past 12 months? 1 □ Yes 2 ☒ No	4☐Pregnant a		□Ectopic pregnancy □ Other (specify)		Month	Day Year
O.	t the by th tache	hys	9 🗆 Unknown	9□ Unknown					
s, P	2 2 5	by P	Part II. Other significant condition	s confributing to death t	out not resulting in the	underlying cause given in Part I.		acco use contribute to	
ğ	w requires t been signe should be o						1 □ Ye.	s 2.⊠No 3.∏Pr	obably 4 Unknown
Record	e law hest je 2 s	Completed					24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
a	iclan: Th certificete rector, pag	င္ပ	25. Was case referred to medical			OC Place - 4 P	1 ☐ Yes 2		2 No
Vital		o Be	examiner? 1 Yes 2 No	Hospital:	ient 2 ER/Outpatie			nce 6 □Other (Spe	cifu)
4	Si G	Ĕ	1 163 EM 140	i winpati	on ELLIVOUIDANE	AT MAISING	Tueside	TO O LICENSE (3per	J. 7/

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicial within 24 hours efter death.

To the Funeral Director: After this cer completely filled in by the funeral direct

State Registrar

Medicai Certification: To

5 Pending investigation

6 Could not be determined

27. Manner of Death

1 X Natural

2 Accident

4 Homicide

29b. Signature and title of certifier

3 Suicide

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 Kanwaljit Nagi, MD 31. Date filed (Month, Day, Year) MAY 0 1 2007

28a. Dafe of Injury (Month, Day Year)

m.D.

32. Registrar's Signature

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

20056063

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

4/26/0

	1	For State Registrer	State of Ma	ryland .	•	artment of F ctificate of			giene Reg. No:	107	13950
Physiciar /Medica	n	Decedent's Name (First, Middle, La	ALFRED	ODEN	WARI	NER, SR	•	2. Date of De Month	Day	Year 2007	3. Time of Death 8:00 P
Examine		4a. Facility Name (If not institution, given Lorien Nursing		· · · · · · · · ·		4b. City, Town, o	Location of Death			unty of Death	
Funeral Director		5. Social Security Number 6. S		(In yrs. last	<i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 6 / 6 / 1	th ay, Year)	9. Birthp	place (State or Foreign ntry) YLAND
faryland ebow		Usual Residence of Decedent t0a. State 10b. County	_	10c. City, T		cation					10d. Inside City Limits 1 ☐ Yes 2 No
ith the M	Jirect	MD CARROL 10e. Street and Number	<u>L</u>	WES	TIATTIA	10f. Zip Code				of What Cou	ntry?
after death w	runeral Director	4308 GEETING 11. Marital Status	RD . 12. Was Decedent E Armed Forces?	Ever in U.S.	t3. \	2115 Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S)	pecify Yes or No Rican, etc.)		Race - American Black, White,	
ours afte	^	1 ☐ Never Married 2 ☐ Married 3 █ Widowed 4 ☐ Divorced	1 XYes 2 ☐ N If Yes, Give Year or Dates: ¶	IIWV		1 □ Yes 2X No	Specify:			ecify: WHI	
I ey, IVI at y I at I LATE 13-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other treumatic event. The Medical Examiner must be motified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) Cotlege (1-4or 5		(Give life. I	dent's Usual Occup kind of work done DO NOT use retired	durina most of wor	king		of Business/In	dustry
Viding Allowith Mental Hygiene arked other that atic event, the atic event, the atic event, the atic event, the atic event, the atic event.	g	17. Father's Name (First, Middle, Last	OHN ODEN	WARN		ODDIEK	18. Mother's Nam	ne (First, Middle	, Maiden Sui	mame)	Y
2 should and Men I e marks	0	19a. Informant's Name/Relationship		-		ng Address (Street					
Pages 1 and nent of Health nut: If item 27 ury or other tr		SHARON E. SPRA 20a. Method of Disposition 1 Burial 2 Cremation 3 [4 Donation 5 Other (Speci	Removal from State	20b. Plac	e of Dispo etery, crer	sition (Name of natory or other place	5/1/	Date 2007	20c. Locat	ER ME ion - City or To BURG	own, State
permit. Pages 1 Department of H Important: If its any injury or ott		21. Ignal (a) Funeral Service Lice		SVEKG.	22	MEM. G Name and Addre	ss of Facility ${ m FL}$	ETCHER	FUNE	ERAL H	
Physician		23a. Part1. Enter the disease, or conshock, or beart failure. List only Immediate Cause (Final disease or condition resulting in death)	pplications that caused one cause on each line	the death. I	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
/Medical Examiner		Sequentially list conditions.	b. Com	a consequen	nic	Henri	t Fruit	Ture		3	Leuks
xecuted and al-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Print Oue to for as:	consequent a consequent	Teles Too of):						to days.
physicie the bur	dicai		d plus	bet	er						25 yrs
The law requires that the death certificate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetat de	ath 3	Ectopic pregnancy Other (specify)	,		23d	. Date of deliv Month	ery Day Year
w requires that been signed by should be deta	2	Part If, Other significant conditions	contributing to death bu	ut not resultir	ng in the u	nderlying cause giv	en in Part I.				he cause of death?
The law recate has be page 2 sho	Completed							24a. Was auto perf t \sum Yes	ormed?	t ☐ Yes	opsy findings available on pletion of cause of
Physicien: this certifica	0 26	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital: 1 Inpatie	nt 2□ER	VOutpatier	nt 3□ DOA Oth	26. Place of Dea er: 4 Nursing H	th (Check only ome 5 ☐ Res		Other (Speci	fy)
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		y Year) 28	3b. Time of Injury	Wor		28d. Describe			
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After compistely filled in by the funeral compistely filled in by the funeral compistely filled in the funeral compistely filled in the funeral compistely filled in the funeral compistely filled in the funeral compistely filled in the funeral compisters of the function of the funeral compisters of the funeral compisters of the function of the funeral compisters of the funeral compisters of the funeral compisters of the funeral compisters of the funeral compisters of the funera	Certification:	3 Suicide 6 Could not l 4 Homicide determined		ury - At home c. (Specify)	e, farm, str	eet, factory, office			(Street and Nown, State)	lumber or Rur	al Route Number.
To the Hospital within 24 hours a To the Funeral C completely filled i	edicai	29a. Certifier t T Certifying P (Check only one) 2 Medical Exe	hysician: To the best of miner: On the basis of and manner sta	examination	edge, death n and/or in	vestigation, in my o	pinion, death occu	, and due to the rred at the time	, date and pla	ace, and due t	o the cause(s)
vith To To	Σ	29b. Signature and title of certifier	milde	to v	14 A	29c. Licens	e number 25443		,	ioned (Month) 32/2	
512		30. Name a gladdress of person who	completed cause of d	eath (Item 20	За) (Туре,				21	157	- 00
State Registra		JOHN WMIDDLE 31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	A BOOT	E RD.	WESTMIN	STER,	MD 21	131	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 April **Physician** 2:30 MCRAE **ANDERSON** 16, Ам /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's 14116 Duckett Road Brandywine 8. Date of Birth (Month, Day, Year Aug. 19, 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex 1 X M 2 □ F **Funeral** Days 1931 528-38-9109 75 Aug. Utah Director Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Prince Geroge's Brandywine 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14116 Duckett Road 20613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after de la Hygiene. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: \$ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer US Government permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If item 27 is marked other? any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rulon Anderson Grace Johnson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14116 Duckett Road, Brandywine, MD 20613 Carmen E. Anderson - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Huntt Crematory 04-17-07 Waldorf, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3035 Old Washington Road M01391 Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 12 Months **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending To the riceproses after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

31. Date filed (Month, Day, Year) APR 1 7 2007

(Check only one)

30. Name an inddress of

29b. Signature and title of certifier

32

and manner stated.

rson who completed cause of death (Item 23a) (Type, Print)

best

29c. License number

29d. Date signed (Month, Day, Year)

		1 - For State Registrar	State of M	larylar		artmen rtificat					Reg. No.	200	-1	13952
Physic	ian	Decedent's Name (First, Middle, La	st)							Date of De Month	ath Day		ear	3. Time of Death
/Med	cal	Leon Braxton		1		45 (25)	Taur			April	12,	200		12:04P ^M
Exami	ner	4a. Facility Name (If not institution, giv Washington Adv			1			Location of	Death			County of I		
Funancia		5. Social Security Number 6. S			iast birthday)	ff Under	1 Year	Park If Under 2	24 Hrs.	8. Date of Bir	th M	ntgo		
Funeral Director			M 2□F	91	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Jan• 2	$y, Y \theta a r$	916 W	Count ashi	ace (State or Foreign ry) .ngton, D.
<u> </u>		Usual Residence of Decedeni				1								ngcon, D.
anylar show	_	DC 10b. County N/A			ty, Town or Lo								10	d. fnside City Limits
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27273-0036 4 within 72 hours after death with the Maryland jiene "naturel", or Items 23a or 28a-f show the Maxical Examinar must be notilized at	Funeral Director	10e. Street and Number				10f. Zip					10g. Citi	zen of Wha	it Count	ry?
s 23a	rai	129 Longfellow			0 10			011				US		
ltem	une	11. Marital Status 1 □ Never Married 2 🕱 Married	12. Was Decedent Armed Forces 1 XYes 2	?	.S. 13.	Was Deced If Yes, spec	lent of Hi cify Cuba	spanic Orig n, Mexican,	in? (Spec Puerto R	offy Yes or No lican, etc.)	-	4. Race - A Black, V		
urs aff	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2XNo	Specity:				Specify: 4		can- ican
Maryland 21215-0035 nd 2 should be filed within 72 hours at lith and Mental Hygiene. 27 is marked other than "natural", or r traumatic event, the Madical Exam	ed	15. Decedent's E	ducation	1770	16a. Dece	deni's Usua	al Occupa	ation			16b. Kir	nd of Busin		
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arylan should be nd Mental marked o	10	Percy Braxton						Hat	tie I	Dorsey				
Maryis d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Турө, Print)		19b. Mailir	ng Address	(Street a	and Number	or Rural	Route Numbe	er, City or	Town, Sta	te, Zip	Code)
s 1 and 2 s 1 and 2 s 1 and 2 s 1 and 2 s 1 and 2 s 1 and 2 s 1 s m 2 s 1 other tra		Gertrude Braxton	- wife					w St.	-		shing	ton,	DC	20011
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Dairlmore, permit. Pages 1 as Department of Hea Important: If Itsm any Injury or othe		21. Signature of Funeral Service Licer	Thou	1200				s of Facility	TICC	Guire H	luner Jashi	al Se	ervi	ce C 20012
ate be executed an interpretation and the burial-transit	ical Examiner	Sequentially list conditions. I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	3 00/540	uence of):				02-1					
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iaw requires that the as been signed by the 2 should be detached.	b	Part If. Other significant conditions of	ontributing to death t	out not resi	ulting in the u	nderlying ca	ause give	n in Part I.			obacco u: /es 2[te to the	cause of death?
The The page	Completed									24a. Was autop perfo 1 Yes		prior deat	to com	sy findings available pletion of cause of
vician: Th ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		,		0#-		of Death	(Check only o	ne)			
	2	17 Yes 2 No	1 U Inpati	Δ	ER/Outpatien			4 🗀 /(u):		e 5 Resid			Specify)	l
Sing After funer	ē	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		Bc. Injury Work			3d. Describe 1	now injury	occurred		
l or Attending Physician: after death. Dirsctor: After this certific in by the funeral director.	Certification;			ury - Al ho	ome, farm, sir	M eel, factory		′es 2□N		3f. Location (5 City or Tox	Street and vn, State)	Number o	r Rural	Route Number,
To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier 1 Certifying Ph	ysician: To the best niner: On the basis o	of my kno	wledge, death	occurred a	at the tim	e, date and	place, an	nd due to the	cause(s)	and manne	r as sta	ted.
To the H within 24 To the F complete	Medicai	Une)	and manner st	ated.					. 55501100					
To To	2	29b. Signature and title of certifier	1-12/-	1.	MA	29c	License		6		29d. Date	signed (M	/	ay, Year)
41		James K.	Lynford,	y,	M. D.		2	232	. •		4	/12/	07.	
7''		30. Name and address of person who												
		James K. Lightfo	ot, Jr.	1300	Piccar	d Dri	ve,	Suite	202	Rock	vill	e, MD	. 2	20850
St Regist		31. Date filed (Month_Day, Year)	32 begistr	ai s Signa	ture	auti s								

4a. Facility Name (If not institution, give street and number) Sunny Woods 4a. Facility Name (If not institution, give street and number) Sunny Woods 5. Social Security Number 045-20-5254 1 M 2 F 89 Yrs. 4b. City, Town, or Location of Death Westminster 4c. County of Death Carroll 4c. County of Death Carroll 4d. County of De			1 - State Registrar			partment of H ertificate of I		Reg	ene) [] /	13953
Examples For Seath Name of the establishing with a variety of the seath of the sea					ff			Month	7, 2007 Year	3. Time of Death 8:30 a M
Output Country Count				re street and number)					4c. County of Dea	
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				2007		Carl.			- 491	

Amended Item 23A Part I, a,b,c per Physician 04/16/2007 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 2წწ7 Anna Margaret Louise Bolland 5:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll 2839 Littlestown Pike Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 30 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** ^{Year)}915 1 □ M 2 □ X Months Days Hours Director 212-05-1253 91 Aug Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. inside City Limits items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Carroll Westminster 1 □Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21158 USA 2839 Littlestown Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Biack, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 20 Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ XNo þ Specify 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home nit. Pages 1 and 2 should be filed variment of Health and Mental Hygie ortant: If item 27 Is marked other I Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fannie L. Naumann Edgar A. Tudor ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane O'Leary/Daughter 2839 Littlestown Pike Westminster, MD21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4/1492007 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. Olivet Cemetery Hanover, PA 21. Signature of Funeral Service License Pritts Funeral Home and Chapel, P.A. ohn X 412 Washington Rd Westminster, MD21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or es a consequence of) Examiner Hypercapnia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Stage 4 Renal Failure Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performe 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Derth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WIL 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Marie Warner 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 6 2007 Registrar

DHMH 17 Rev 1/2001

	For State Registrar			State	or ivia	ylalic		rtifica			ario iv	lental H	Reg.	0.0	107	Mary Taranta	395
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		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death		
Physic /Med		Sara Alice Boyd			I	April 14		12:23P ^M		
Exam		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Lo	ocation of Death		4c. County of I	Death		
		389 Ridge Road		Rising				ecil		
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permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. d Forces? es 2 💆 No , Give or Dates:	If Yes, specify Cuban,	/as Decedent of Hispanic Origin? (Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2【X No Specify:			American Indian, White, etc.		
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To the Hospitel or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date o Month			
that hed b	by Pr	Part II. Other significant conditions contributing	to death but not resulting in th	e underlying cause given	in Part I.	23e. Did tobacc	co use contribu	ite to the cause of death?		
d big						1 🗌 Yes	2 No 3[Probably 4 Unknown		
s bee	Completed					24a. Was an	24b. Wei	re autopsy findings available		
The la The la te ha	E O					autopsy performed	dea	r to completion of cause of th? Yes 2 No		
an: an: rtifica	a)	25. Was case referred to medical		2	6. Place of Death	(Check only one)	NO I	103 21210		
ysici is ce direc	To B	examiner? 1 Yes 2 No Hospital:	□ Inpatient 2 □ ER/Outpa	itient 3 DOA Other:	4 Nursing Hon	ne 5 XResidence	6 Other	(Specify)		
nding Pt ath. r: After th e funeral		27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	ate of Injury 28b. Tim Month, Day Year) Inju	ry Work?	t 2 s 2 □No	8d. Describe how i	njury occurred			
el or Atte s after dei il Directo	Certification:	3 Suicide 6 Could not be determined 28e. F	lace of Injury - At home, farm uilding, etc. (Specify)	, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
ne Hospil 24 hour ne Funera aletely fills	edical	(Check only 2 Medical Examiner: On t	o the best of my knowledge, d ne basis of examination and/o manner stated.	e(s) and manne and place, and	er as stated. I due to the cause(s)					
To the Vithin To the comp	W	29b. Signature and title of certifier	Colul	29c. License n	-	3	Date signed (M	Month, Day, Year)		
6		30. Name and address of person who completed M. Hosford-Skapof, M.				E1kton	MD 210	21		
	tate	31 Date filed (Month Day Year)	2 Registrar's Signature		110 104,	LIKEOH,	.ID 213			
Regis		APR 1 7 2007	Aloena H	Specker						

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

		For	State of Maryl				lental Hygi	ene	
		State Registrar		Cei	tificate of L	Death	Re	g. No. 200	7 395
Physici	ian	1. Decedent's Name (First, Middle					2. Date of Death Month	Day Year	3. Time of Death
/Media	cal	Gladys	C		Belle		April	10,2007	10:55p ^M
Examin	ner	4a. Facility Name (If not institution		-	4b. City, Town, or			4c. County of Dea	
Funeral	% L	Southern Mar 5. Social Security Number		al yrs. last birthday)	Clinto		8. Date of Birth	Prince 9. Bit	Georges thplace (State or Foreign
Director		217-34-2177	1□M 2X F 7	0 Yrs.	Months Days	Hours Min.	(Month, Day, 12/26/	Year) C	ountry) rvland
p ,		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo				7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	
shov shov ed at	<u>ا</u>								10d. Inside City Limits 1 X Yes 2 □ No
the N 28a-f notiffi	Director	Maryland Prin	ce Georges	Brandyw	10f. Zip Code		10	g. Citizen of What C	
aa or		6701 Floral	Dark Boad			610			ountry?
death ms 2: mus	Funeral	11. Marital Status	12. Was Decedent Ever i		Vas Decedent of His	513 spanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Amo	erican Indian,
s 1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mental Hygiene. If Health and Mental Hygiene. To marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 🔏 Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		f Yes, specify Cubar I □ Yes 2 X No	n, Mexicari, Puerto Specify:	Rican, etc.)	Black, Whi	
72 ho natur lical E	Completed	15. Deceden	t's Education st grade completed)	16a. Deced	lent's Usual Occupa	tion	(a.a.	6b. Kind of Business	/Industry
ithin an "I	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done di OO NOT use retired)	uring most of work	ing		
led w lygier her th		12			Cook			Nursing	Home
t be findal Hed of	Be	17. Father's Name (First, Middle,		7 .	i	_	e (First, Middle, M	,	
hould of Me mark matic	ဥ	James 19a. Informant's Name/Relations	hip (Type Print)	Washin	gton	Rebecc	a al Bauta Musakan	Br	own
Ith an Ith an 27 is it trau		Earl P. Belle	, , , ,	6701	Floral	Dawle D.	ai Houte Number,	City or Fown, State,	Zip Code) 20613
permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition	20	b. Place of Dispos	sition (Name of patery or other place	Palk K		ywine, Ma	
Page ent o nt: If ry or		1 █ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 Linemoval from State	-	y Memori	í	8/07 W	aldorf	Maryland
permit. Departm Importa any Inju		21. Signature of Superal Service			Name and Address	of Facility Ad	ams Fun	eral Hom	o DA
88 = 88	111 9	Zest							land 20608
4		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the doily one cause on each line.	death. Do not ente	er the mode of dying	, such as cardiac	or respiratory arres	st,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	MULTIF	'LE N	HELDM	A			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a con-	sequence of):					
411	_	Sequentially list conditions,	b. KIDNE	FA	ILURE				
nsit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	A-NIENI	1 /A					
execting and ial-tra	Exa	resulting in death) Last	Due to (or as a cons	sequence of):					
icate be executed physician and s the burial-transit	edical		d						
		IS SERVALE.							
The law requires that the death certific tate has been signed by the attending page 2 should be detached for use as it	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
that ti		Part II. Other significant condition	ons contributing to death but not	resulting in the un	derlying cause giver	n in Part I	23e Did toba	acco use contribute to	the cause of death?
w requires that the dibeen signed by the should be detached	ted by						1 Tyes		
e 2 sh	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
: The cate has page	Con						perform	ed? death? No 1 ☐ Yes	
sician: The law certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				(Check only one)		
Phys r this ral dii	٠. T	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatient 28b. Time of		4 Li Nursing Ho		ce 6 Other (Spe	cify)
ding th. : Afte : fune	tiol	1 Natural 5 Pendin 2 Accident investig	g (Month, Day Year		28c. Injury Work? M 1 1 7	es 2⊡No	28d. Describe how	injury occurred	
Atter r deal ector by the	Certification:	3 ☐ Suicide 6 ☐ Could r	not be 28e. Place of injury - A	t home, farm, stre			28f. Location (Stre	et and Number or Ru	ural Route Number.
al or	ert	4 ☐ Homicide determ	building, etc. (Spe	ecity)			City or Town,	State)	,
	ledical (29a. Certifier (Check only one)	g Physician: To the best of my Examiner: On the basis of examand manner stated.	knowledge, death nination and/or inv	occurred at the time estigation, in my opi	e, date and place, nion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as te and place, and due	s stated. e to the cause(s)
ompl	Me	29b. Signature and title of certifie			29c. License	number	290	d. Date signed (Mont	h, Day, Year)
		Manus	Quaire		DAS	8158	A	PRIL 11, 2	4007
		30. Name and address of person	who completed cause of death (I		Print)				
33		SISOM OSIA,	6192 OXON H10 32. Phistrar's Si 7 2007	L ROAD	#500	H MOXO	ILL ME	2074	5
Stat		31. Date filed (Month, Day, Year)	7 2007 Sistrar's Si	gnature	and a				
Registra	ar	APR 1	7 2007 Streve	10 169	A STATE OF THE PARTY OF THE PAR				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Marylar 1 - State AMEND#23apenMD4/18,07,BMW,MbCb	•	artment of H rtificate of l			Iene eg. No. O O O T	12050		
8	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month April		3. Time of Death		
Silver	/Medic	al	Leonard E. Cohn 4a. Facility Name (If not institution, give street and number)		4b City Town or	Location of Death	Aprii	4c. County of Death	9:30 А м		
7	Examin	er	Montgomery General Hospital		01ney			Montgomery			
Ī	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. 1 A	82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 3	Year) 1925 Wa	place (State or Foreign stry)		
	/land ow at		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ity, Town or Lo	cation			1	0d. Inside City Limits		
	e Man la-f sh tified	ctor	Maryland Montgomery Sil	lver Sp	ring				1x Yes 2 No		
	with th	Dire	10e. Street and Number		10f. Zip Code 2090	26	1	Og. Citizen of What Coun	itry?		
	ms 23	Funeral Director	3397 S. Leisure World Blvd. 11. Marital Status 12. Was Decedent Ever in U	J.S. 13. \		ilspanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race - Americ			
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Arm Year or Dates: WW 2	my	If Yes, specify Cuba 1 ☐ Yes 2 No		Rican, etc.)	Black, White, Specify: Wh	etc. ite		
Maryland 21215-0036	n 72 ho "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	ing	16b. Kind of Business/Ind	dustry		
212	d within giene. er than " the Med	omo	Elementary/Secondary (0-12) College (1-4or 5+) 5+	Reta				Books			
Pu	be filed Ital Hygi Id other event, tl	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name Bertha		flaiden Surname)			
ryla	2 should the and Menter is marked aumatic e	은	Myer Cohen 19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	na Address (Street			, City or Town, State, Zip	Code)		
	and 2 s ealth ar n 27 is her trau		Aaron Brad Van Grack - Son					ing, Marylan			
Baltimore,	Pages 1 and the properties of		177 Puriol 2 Cromotion 2 TRemovel from State	cemetery, cren	osition (Name of matory or other place id Mem. G	dns 4/15		20c. Location - City or To Falls Church			
Balti	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Licensee Conald Usttlemus					ion, Inc. ille, Maryla	and 20852		
			23a. Part1. Enter the disease, or complications that caused to dea shock, or heart failure. List only one cause on each line	th. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition a. e. c. c. c. c. c. c. c. c. c. c. c. c. c.	TIVE	HEA	RT F	FAILU	RE	DB-45		
	Examiner		Due to (or as a consec		AR 1	PNEUM	NIA		hAUC		
	po tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):	7		-277				
	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	quence of):							
68760,	ficate be executed physician and sthe burial-transit	edical E	d								
	# D &	/Med	IF FEMALE: 23c. If yes, outcome pf pregn	ancy							
.O. Box	requires that the death certifi een signed by the attending hould be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	tal death 3□	□Ectopic pregnancy □Other (s <i>pecify</i>)	/		23d. Date of delive Month	ory Day Year		
Δ.	ss that gned b	by Pr	Part II. Other significant conditions contributing to death but not res	-	nderlying cause giv	en in Part 1.	23e. Did tot	pacco use contribute to the	ne cause of death?		
ord	tw requires that s been signed to should be deta	ted	Acute mystandial inforced	/	Trotales	hypor	1 O Ye	es 2 No 3 Prot	ably 4 Hinknown		
or Vital Records,	e law has b je 2 sl	Completed	lovain , TH, (ND	G/101	Curent	UQ-	24a. Was a autops perfor	sy prior to co	psy findings available mpletion of cause of		
ta		Be Co	25. Wa case referred to medical	ia, hyp	pothyroid	26. Place of Deat	1 Yes	2. □ Hro 1 □ Yes	2 No		
<u> </u>	S S =	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Hopatient 2 ☐			er: 4 ☐ Nursing Ho		ence 6 □Other (Specif	ý)		
ouo	ding In. After funel	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	ow injury occurred			
Division	ata	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At h	I nome, farm, stri ify)			28f. Location (St City or Town	treet and Number or Rura n, State)	al Route Number,		
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kn 2 Medical Examiner: On the basis of examinand manner stated.								
	within 24	Me	29b. Signature and title of certifier		29c. Licens		29d. Date signed (Month, Day, Year)				
6 Shulladhateun, M. Dooste							57630 04-12-2007				
			30. Name and address of person who completed cause of death (Iterative Anuradha Arun MD 10301 Georg:			Silver Sp	ring MD	20902			
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 7 2007 32 Tegistrar's Sign		alls)				V.		

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

ORIGINAL

Months

Certificate of Death

4b. City. Town, or Location of Death

ROCKVILLE If Under 1 Year | If Under 24 Hrs.

Hours

Min.

Days

MARY FYFFE CHISWELL

ADVENTIST

1 □ M 2 🗙 F

6. Sex

HOSPITAL

7. Age (In yrs. last birthday)

SHADY GROVE

Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County show la or 28a-f show t be notified at MD MONTGOMERY POOLESVILLE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17606 W. WILLARD RD. 20837 "natural", or items 23a or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any lijury or other traumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give-Year or Dates: <u>6</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL TEACHER TEACHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ISAAC FYFFE ELIZABETH DADE DARBY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN FYFFE / COUSIN P.O. BOX 93, POOLESVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MONOCACY CEMETERY 4/17/07 BEALLSVILLE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, W 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SUDDEN CARDIAC DEATH /Medical Due to (or as a consequence of): **Examiner** ATRIAL FIBRILLATION WITH RVR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner PNEUMONIA burial-trai Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical ACUTE RENAL FAILURE IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 CONGESTIVE HEART FAILURE 1 | Yes 2 | No 3 | Probably 4 Munknown Completed 24a. Was an was an autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Injury 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4/14/07 D064444 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DR., ROCKVILLE, MD 20850 ARIJIT DASGUPTA, MD h, Day, Year) 32. Raistrar's Signature 31. Date filed (Month. State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

2. Date of Death 3. Time of Death

MONTGOMERY

Country) MD

2:20 A M

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

2007^{ea}

4c. County of Death

USA

Specify:

Black, White, etc.

20837

20838

HOUR

DAYS

DAYS

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

Approximate Interval Between Onset and Death

MINUTES

WHITE

APRIL 14

8. Date of Birth (Month, Day, Year) OCT 8 1902

			For State Registrar	State	of Maryla	and / Depa	artment					iene	0.7	13962	
	Division	ð.	1. Decedent's Name (First, Midd	ile, Last)						2	2. Date of Dea			3. Time of Death	
	Physic /Medi		Sherman Jun	ior Chr	istian						Month April	13,20	007	1:18p M	
	Exami		4a. Facility Name (If not institution	on, give street and r	umber)		4b. City,	fown, or	Location	of Death	4c. County of De				
	,	18	Union Hospi				E1k					Cecil			
	Funeral		5. Social Security Number	6. Sex X M 2 ☐ F		rs. last birthday) 4 Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	B. Date of Birth (Month, Day	9. Birthplace (State or Foreig 10, 1942 VA			
	Director		228-56-7331 Usual Residence of Decedent		0	113.				UÇ	toper	10,19	142	VA	
	/land		10a. State 10b. Count	у	10c. (City, Town or Lo	Location						10d. Inside City Limits		
	h the Maryland r 28a-f ehow	ţō	MD Cec	i 1		Elkto	n							1 ☐ Yes 2€ No	
	or 284	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Cou	ntry?	
	th w		25 St. Mic	haels Ct			2	192	1			U.S	S.A.		
	Items	Funeral	11. Marital Status	12. Was Oe Armed I	cedent Ever in	U.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Speci	fy Yes or No- can, etc.)		ce - Ameri		
36	a o E	y Fu	1 Never Married 2 Ma	rried 1 Tyes	2 € No		1 Yes 2		Specify:		can, etc.)	Speci	ack, White,	nite	
5-0036	n 72 hours after "natural", or Ite	d by	3 Widowed 4 Divorce		Dates:							Speci	iy. VVI	1106	
15	- 34	Completed	15. Decede (Specify only highe	nt's Education est grade completed	1)	16a. Dece	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of B	Business/In	dustry	
12	within ene. then	ш	Elementary/Secondary (0-12)	College	(1-4or 5+)		todi		,			Educa	tion		
D	filed with Hygiene other the	BeC	17. Father's Name (First, Middle	, Last)		Cub	cour	411	18. Mothe	er's Name (First, Middle, I			1	
an	ould be f Mental I Mrked of	ToB	Charles R.	Christia	n						ryant		,		
Maryland 2121	d 2 should be filed within the and Mental Hygiene. 7 Is marked other than traumatic event, Ine M.	-	19a. Informant's Name/Relation			19b. Mailir	g Address	(Street a			Route Number	City or Town	ı, State, Zic	Code)	
	alth alth a 27 lb		Deborah J.	Christia	an/Wif						., E1k			21921	
altimore,	es 1 and 2 of Health of Item 27 r other tra		20a. Method of Disposition	0 DD		. Place of Dispo	sition (Nam	e of her place	2) -	Dat	- 1	20c. Location	- City or To	own, State	
Ĕ	Page nent o ant: If ary or	8	1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State G	ilpín			Ap	ril 2007	18,	Elkto	on, N	1D	
alt	permit. Page Department Important: If any injury o		21. Signature of Edneral/Service	Licensee	,	22	Name and		s of Facilit	у		77			
8	20 = 20	2 0	Video				250	F I	Main	9+	unera] , Elkt	on N		21921	
		8	23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause on	caused the de each line.	ath. Do not ent	er the mode	of dying	, such as	cardiac or r	espiratory arre	est,	110	Approximate Interval Between	
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	/Medical Examiner		resulting in death)	Due to	oras a conse	equence of):									
		-	Sequentially list conditions,	b	400	ele -	nuc	×C	och	10	npa	moun	0		
	ted nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to	(or as a conse	equence ot):	9			1	- 1				
	be executed ician and burial-transit	хаг	that initiated events resulting in death) Last	c. Due to	(or as a conse	equence of :	10	40	-	ans.		0			
190		cal						1							
99	certificate iding physise as the	70													
Вох	leath certifica attending ph i for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of preg							23d. Da	ate of delive	erv	
	the atter	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2 ☐ Fe nant at time of		Ectopic pre Other (spe						onth	Day Year	
P.0	± ≥ ≥	hys	9 Unknown	9□ Unki											
	w requires that s been signed t should be deta		Part II. Other significant conditi	ons contributing to	death but not re	sulting in the ur	iderlying ca	use give	n in Part I.		23e. Did tob	acco use con	tribute to th	ne cause of death?	
ord	requires sen sign nould be	ted	Dobe	+6-2							1000	s 2 🗆 No	3 Prob	ably 4 Dunknown	
Vital Records,	10 - 14	Completed by	-hoph a	shole	ser						24a. Was an	24b.	Were auto	psy findings available mpletion of cause of	
H	The asternation	S									perform	ed?	death?	2 No	
Vit.	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:		,				of Death	Check only one				
	Q is	٥ ۲.	1 ☐ Yes 2 📉 No 27. Manner of Ceath	16	Inpatient 3	R/Outpatien			4 🗀 1401		5 Reside			y)	
LO	ding Ph h. After th funeral	盲	Natural 5 ☐ Pendir		of Injury oth, Day Year)	28b. Time of Injury	M 28	Work	at ? es 2.∏.N		d. Describe ho	w intury occur	rred		
Division of	Attending r death. • ctor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could	not be	e of Injury - At	home, farm, stre					Location (Str	eet and Num	hor or Our	I Route Number.	
Ö	after Dire	Certification:	4 Homicide determ	build	ling, etc. (Spec	cify)	ou, radiony,	Omos			City or Town	State)	oer or riura	THOUSE HUMBER,	
	To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the	0	29a. Certifier	ng Physician: To th	e best of my kn	nowledge, death	occurred at	the time	e. date and	d place, and	d due to the ca	use(s) and m	anner as st	ated	
	he Ho n 24 he Fu	edical	(Check only 2 / Modical one)	Examinat. Of the	pasis of examination of stated.	nation and/or inv	estigation, i	n my opi	nion, deat	h occurred	at the time, da	te and place,	and due to	the cause(s)	
	To t To t	Σ	29b. Signature and title of certifie	or		^		Licensa				d. Date signe			
			Meldos	ouppo	ull		17	00	060	242	6	4/16	1200	07	
	,		30. Name and address of person	who completed cau	se of death (Ite	om 23a) (Type, I	Print)		. ~	_	6.	SILL	. 1	10	
	4		21 Date filed (Marsh San V	ZNacret	- L, M	ひ	200	SU) \$ 1 %	A()	○ 1 .	_ , _ , _ ,	· // `		
	Sta Registr		31. Date filed (Month, Day, Year)	7 2007	istrar's Sign	J. A	rede								

For

		1 - State Registrar			Cei	rtificate o	f Death			Reg. No		1 10	100
DI		1. Decedent's Name (First, Middle,	Last) Larry	Marvin	C	unningh	am		2. Date of De Month	eath Da	av V	3. Time	e of Death
Physici /Medio		Larry	M. J	Cu	nnir	igham -			April	23			5 A M
Examir		4a. Facility Name (If not institution,	give street and number,			4b. City, Town	, or Location of	of Death		40	c. County of I	Death	
		17101 Miner Av	e				stown					ington	
Funeral			5. Sex 7. Aq 1 X M 2 ☐ F	ge (In yrs. last b		If Under 1 Ye Months Day		24 Hrs. Min.	8. Date of Bi (Month, Da	av. Year	9.	Birthplace (Star Country)	te or Foreign
Director		219-44-2564	125 2	60	Yrs.				May 20), 19	946 M	aryland	
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside	e City Limits
Many f	ō	MD Washi	natan	Ис ост								1 🗆 Y	es 2X No
the 1	Director	10e, Street and Number	Ington	Hage	rsto	10f. Zip Code	9			10a. C	itizen of Wha	at Country?	
Sa or	0	17101 Miner Ave				217					U.S.A	_	
me 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.1	Was Decedent of If Yes, specify C		gin? (Spe	ecify Yes or No	0-		American Indian	1,
after or Ite		1 ☐ Never Married 2 ☐ Marrie	Armed Forces		1			1, Puerto	Rican, etc.)			White, etc.	
reli.	ğ	3 ☐ Widowed 4 1 Divorced	If Yes, Give Year or Dates:			1□Yes 2XIN	lo Specify:				Specify:	White	
filed within 72 hours after death with the Maryland Hygiene. sther then "neturel", or Items 23s or 28s-f show ent, the Madical Examiner must be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)	16	(Give	dent's Usual Occ	ne durina mosi	t of work	ing	16b. l	Kind of Busin	ess/Industry	
Athin ne. hen	gu	Elementary/Secondary (0-12)	College (1-4or		life.	DO NOT use ret	ired)			_			
led w tygies her ti		9		T	ire	Recycle	-		- (***) - 1 1 1 1 1 1 1 1		ubber		
be fi	Be	17. Father's Name (First, Middle, L.							e (First, Middle		n Sumame)		
3 Mer	မ	Lawrence Cunning		40					Marti			. 7.0.11	
12 sl h an 7 ls r traur		19a. Informant's Name/Relationshi				ng Address (Stre Miner							
1 and Healt em 2	١.	20a. Method of Disposition	girdiii/ CX WII					7.0	Date			y or Town, State	1
nt of mt of Htt:		1 ☐ Burial 2 M Cremation 3				nsition (Name of matory or other p	,						ľ
ift. Purture		4 □ Donation 5 □ Other (Special Service Li		Smith		g Crema					thsbur	g, MD Chapel	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "neturel", or Items 23s or 28s-f show sny Injury or other traumatic event, the Medical Examinal must be notified at once.		S. Mark Sui				01 Penn						-	742
		23a. Part1. Enter the disease, or c	on plications that cause	od the death. Do							scowii,	Approxir	
		shock, or heart failure. List o Immediate Cause (Final	nty one cause on each l	ine				our arao t	or respiratory t	arrost,		Interval	Between nd Death
Physician /Medical		disease or condition resulting in death)	_ a	yo Card	19	infar	ction						
Examiner			Due to (or as	s a consequence	9 Of):	V							
	er	Sequentially list conditions,	b. Due to for se	t a our saduelrie	oth:							_	
Posit ge	m.	causé. Ente Underlying Cause (Disease or injury that initiated events c.											
tificate be executed g physicien and as the burial-transit	Examin	that initiated events resulting in death) Last Due to (or as a consequence of):											
e be /sicie e bur			d										
certificate be executed rding physicien and ise as the burial-transit	/Medical												
		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Petal deat	h 3	Ectopic pregna	ncv				23d. Date o	f delivery	
deal	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death		Other (specify)					Month	Day	Year
at the	Å.	9 Unknown			_				-				
res that the death or igned by the atten be detached for u	þ	Part II. Other significant condition	A .				given in Part I.					ite to the cause	
w require been si should t		Type 2 d	averes, c	mgest	ve	heen	4911m	e	1 🗷	Yes 2	2 □ No 3[Probably 4	Unknown
ne lawr has be ge 2 sh	Completed			1					24a. Was		24b. Wer	re autopsy findin r to completion o	igs available
The ate h page	Ö								perfe	ormed?	dea	th? Yes 2□ No	
cian: ertific	Be (25. Was case referred to medical examiner?					26. Place	of Deatl	h (Check only	one			
Attending Physician: The sr death. e death. ector: After this certificate he by the funeral director, page	ျ	1 Yes 2 No	Hospital: 1 Inpati		utpatien	I SEL DOA		rsing Ho	me 5∑Res	idence	6 Other (Specify)	
Ing P	<u>e</u>	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju	ury ay Year) 28b.	Time of Injury		jury at vork?		28d. Describe	how inju	ury occurred		
tendleath.	cat	2 Accident investiga 3 Suicide 6 Could no	t he				Yes 2 1			-			
or At fter d Nreci	ertification;	4 Homicide determin	Ad 200. Place of in	ijury - At home, i tc. <i>(Specify)</i>	larm, str	eet, factory, offic	Э		28f. Location (City or To	(Street a wn, Stat	ind Number (te)	or Rural Route N	lumber,
urs al oral D	O									_			
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the complete of	edical	29a. Certifier 1 Certifying (Cneck only one)	Physician: To the best caminer: On the basis of	ot examination a	ge, death indvor in	h occurred at the vestigation, in m	time, date an y opinion, dea	id place, th occurr	and due to the red at the time,	cause(: , date an	s) and manne nd place, and	er as stated. I due to the caus	60(S)
thin 2	Med	29b. Signature and title of cartelier	and manner st	12190.		29c Lice	nse number			29d D:	ate signed (A	Month, Day, Yea	(r)
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H		30. Tame a address of person w	no completed cause of	ueath (Item 23a)	dica	1 Busan	s Brown	15.	te ins	Ho	wereto.	/2007	2174
Sta	ite	31 Date filed (Month, Day, Year)	32. Begist	rar's Signature		,			- 10/	, , , , ,	7		-//
Registi		MAY 0 1	מחחק א	rar's Signature									
HMH 17 Rev 1/2	001		- COL	15	CON	W.							
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DHMH 17 Rev 1/2001

			For State Registrar	State of N	Maryland / Depa	artment of H		·	giene Reg. No.	7 139	164	
I	° Physici	an	1. Decedent's Name (First, Middle					2. Date of De	eath 3. Time of Death Day Year			
I	/Medic	al	Winnifred	Ann	and .	Custer	- Lagatina - 6 F	APRIL	4c. County of Death			
	Examir	ier	4a. Facility Name (If not institution Julia Manor He.	•	•	4b. City, Town, or Hagerst		Death	Washington			
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	rth 9 Birthplace (State or Foreign			
	Director		214-28-7217	1□M 2X F	74 Yrs.	Months Days	Hours	May 19	1932	Maryland		
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
	Maryli f sho	ō	MD Washi	naton	Hagerst						2 No	
	r 28e	rect	10e. Street and Number	I G COIL	nagerst	10f. Zip Code			10g. Citizen of V	Vhat Country?		
	th witl	Funeral Director	11 W. Baltimore	s St.		21740			U	U.S.A.		
	r dea	ner	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin In, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	14. Rac Blac	e - American Indian, k, White, etc.		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🛣 Divorced		ΩNo	1 ☐ Yes 2X No			Specify			
2-003 6	within 72 hours after death with the Maryland ene. then "natural", or Items 23g or 28e-f show he Mcdical Examinar must be malified at	ed k	15. Deceden	t's Education	16a, Dece	dent's Usual Occupa	ation		16b. Kind of Bu	White usiness/Industry		
213	hin 7;	plet	(Specify only highes Elementary/Secondary (0-12)	st grade completed) College (1-4o	r 5+)	kind of work done of DO NOT use retired						
7		Completed	12		Assist	ant Shipp		illager	l	Manufact	uring	
and	d tal	Be	17. Father's Name (First, Middle,	,				Name (First, Middle		e)		
\leq	should nd Men marke umetic	2	Jacob Frank W13 19a. Informant's Name/Relations		19h Maili	na Addraga /Strant		Helena Go		State Tip Code		
Z	0 0 0 0		Jay F. Wiles/Bi			•		d, Hagerst		21740		
ā,	es 1 and 2 of Health fitem 27 r other tra		20a. Method of Disposition		20b. Place of Dispo	4.00	1	Date		City or Town, State		
altimore,	@ O == ==		1 X Burial 2 □ Cremation `4 □ Donation 5 □ Other (S		te	en Cemete		27/2007	Hagerst	own, MD		
<u></u>	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service	Licensee				Rest Have	n Funer	al Chapel		
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8/60,	Physician /Medical Examiner prize and prize transit the prize transit the prize transit prize transi	Ilcal Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a c.	as a consequence of): LAL as a consequence of): LAL as a consequence of):	ve de de de de de de de de de de de de de	lear Suff Tu	e Par ficien	une ney	Approximal Interval Bet Onset and MONU Year Year Year	Ween Death S	
O. Box 6	death certific e attending p d for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Dat	e of delivery nth Day	Year	
ds, r	requires that the de een signed by the a rould be detached f	by	Part II. Other significant condition	ins contributing to death	but not resulting in the u	nderlying cause give	en in Part I.	~ 11		bacco use contribute to the cause of death? Ses 2 □ No 3 □ Probably 4 □ Unknown		
l Hecord	The law ate has b page 2 sh	Completed		9017501	mless	nal	beec		osy primed?	Vere autopsy findings rior to completion of c leath? □ Yes 2 □ No	available ause of	
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10	di S	. To	1 ☐ Yes 2☐ Mo 27. Manner of Death	Hospital: 1 ☐ Inpa 28a. Date of In			4 U. Piursi	ing Home 5 Resid				
0	ding Phys h. After this funeral di	tlon	1 Matural 5 ☐ Pendin	g (Month, E	Day Year) Injury	Work	rat ⟨? Yes 2 □ No		now injury occurr	ed		
VISION	Atten r deal sctor: by the	ertification:	3 ☐ Suicide 6 ☐ Could of	not 28e. Place of I	Injury - At home, farm, str			28f. Location (er or Rural Route Num	nber,	
5	s afte s afte el Dire	Cert	4 Homicide	building,	etc. (Specify)			City or To	vn, State)			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	edical (29a. Certifier 1 Certifyin (Check pnly one)	g Physician: To the bes Examiner: On the basis and manner:	st of my knowledge, death of examination and/or in	h occurred at the tim vestigation, in my op	e, date and pointion, death	place, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s	s)	
	o the	Med	29b. Signative and title of certifier		Jiaiou,	29c. License	number		29d. Date signed	(Month, Day, Year)		
	C > F 0		Jehun n	EINDIA	M)	20	045	031.	April	25 200	2	
			30. Name and address of person	who sempleted cause of	f death (Item 23a) Type.	Print)	0 0	/	1210	- 0-7		
	1		19419 C Ce	ilersou	rf th	1399	4881	own	MD	21742	2	
	Sta Registr		31. Date filed (Mooth, Day, Xear)	2007 32 Regis	strar's bignature	artis /				,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 April 13, Рм 2:22 Anthony John Dabbondanza 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Calvert North Beach 9100 Greenwood Ave 8. Date of Birth July 23, 1922 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) Months Hours 1₩ 2□F 84 Yrs 577-24-4520 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No North Beach MD Calvert County 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20714 9100 Greenwood Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XNever Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Self-Employed Barber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pauline Pignatello Louis Dabbondanza 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vincent M. Dabbondanza (Nephew) | 19012 Jonesville Terrace, Poolesville, MD 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Brentwood, Maryland Fort Lincoln Cemetery 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Fuo Michael W. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CORONARY ARRHYTHM disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? L. YPERTENSION 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

Physician

/Medical

Examiner

Funeral Director

Be Completed by

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatht and Mental Hygiene. Intent of Heatht and Mental Hygiene. Intent of Heatht and Confert than "natural", or items 23a or 28a-f show mit. If item 27 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division or Vital Records.

Examiner Physician/Medical Completed by Be Certification: To

sician and burial-transit The law requires that the death certificate be executed the as ed by the a detached f To the Hospital or Attending Physician; this After thi funeral death. Director: within 24 hours a To the Funeral I

28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40370 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20678 110 Hospital Road Prince Frederick, MD MDPeter Wisniewski,

31. Date filed (Month, Day, Year) APR 1 7 200

27. Manner of Death

1 Natural

29a. Certifier

Medical

State Registrar 28b. Time of

28a. Date of Injury

			For State Registrar	State o	f Marylan		artment of F ctificate of		-	11	44.9	1 1 1 1 1 1 1 1	
a se	20 0		Hegistrar Decedent's Name (First, Middle, La	ıst)			- Inouto or		2. Date of De				
	Physicia /Medic		Howa		R		Dickensh	eets	Month April	16	2007	11:37 P M	
Y	Examin		4a. Facility Name (If not institution, given	e street and nu	mber)		4b. City, Town, o	r Location of Dea	th	4c. County of Death			
		ing the second	Frederick Memori				Freder:			Frederick			
T A	Funeral Director			Sex 1☐M 2☐F	7. Age (In yrs. 8		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th Year) , 1922	9. Birthp Cour Mary		
	and w		Usual Residence of Decedent 10a. State 10b. County		10c, City	/. Town or Lo	cation				Od. Inside City Limits		
	Maryli f sho ed at	5	Maryland Freder	ick	Free	derick				1 □Yes 2 □ No			
	the 1	rect	10e. Street and Number	ICK	1100	ICLICK	10f. Zip Code			10g. Citizen of	What Cour		
	h with		8921 Baltimore R	oad			21704	ŀ		U.5	S.A.		
	ems ?	Funeral Director	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U.	S. 13. \	Was Decedent of H	lispanic Origin? (Specify Yes or Norto Rican, etc.)		ce - Americ		
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes If Yes, Gi Year or D	2 X □ No ve		1 □ Yes X □ No	Specify:		Specia	fv:	ite	
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pu	be file	Be	17. Father's Name (First, Middle, Las		00+a C 1	_			me (First, Middle	, Maiden Surna	ne)		
<u>√</u>	Menda Menda Marke	ို	Howard Raymond D		eets, si		ng Address (Street		L. Hahn	on City on Town	Ctata 75	- 0-4-1	
Maryland	nd 2 shalth and 27 is n		19a. Informant's Name/Relationship Sylvia M. Dicken		/ Wife		Baltimor					Code)	
re,	ss 1 a of Hea item		20a. Method of Disposition	70 14	1 6	lace of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location	- City or To	own, State	
imo	Pages nent of I ant: If ite ury or o		1 ፟፟፟፟ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (<i>Spec</i>				et Cemete		0/07	Frederi	lck, 1	Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	alest	14	₹0	DBERT E.	SS OF FACILITY & MARKET	SON FU	NERAL HO)MES,	P.A.	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List off	plications that	aused the death							Approximate Interval Between	
	Physician [*]		Immediate Cause (Final disease or condition	50	05.5							Onset and Death	
N.	/Medical Examiner		resulting in death)	Due to	(r as a consequ	uence of):						_	
	LXammer	<u>.</u>	Sequentially list conditions,	b. — Due to	(or as a consequ	uence of):					_		
	ned nsit	mìne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Cisease of it it)	20/100 01/.				23					
Ć,	execun and ial-tra	Examiner	that initiated events resulting in death) Last	c Due to	(or as a consequ	uence of):							
8760,	cate be executed physician and the burial-transit	dical		_ d									
9	rtifica ng ph as th	/ledi	IE EEMALE:										
Вох	ath ce tendii	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	itcome pf pregna birth 2 ☐ Feta	Ideath 3	Ectopic pregnanc	y			ate of delive	ery Day Year	
0	The law requires that the death certifi te has been signed by the attending bage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Preg 9⊟Unkr	nant at time of d nown	eath 5□	Other (specify) _				571417	Day Tou.	
<u>α</u>	that the	y Ph	Part II. Other significant conditions	contributing to d	leath but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use cor	tribute to t	he cause of death?	
rds	w requires that s been signed b should be deta	d by	Dehydration		-				1 🗆	Yes 2 □ No	3 ☐ Prob	bably 4\Denknown	
000	aw re s bee 2 shor	Completed	1						24a. Was			ppsy findings available	
Ĕ	The lav cate has page 2:	mo							auto perf 1□ Yes	ormed?	death?	mpletion of cause of 2 No	
ita	rysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?					26. Place of De	eath (Check only				
Z \	lys dirigi	일	1 ☐ Yes 2 ☐ No	Hospital: 1 28a. Date		ER/Outpatier		4 Li Nursing	Home 5□Res			fy)	
Division or Vital Records,	ding F	jon:	27. Manner of Death 1 Natural 5 Pending	Wo	ryat rk? Yes 2 ∐ No	28d. Describe	how injury occu	rred					
isio	or Attending after death. Director: Aftel in by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not I	e lan Plan	e of iniury - At ho	ome, farm, str	eet, factory, office	res 2 🗆 No	28f. Location	Street and Num	her or Rus	al Route Number,	
Ω̈́	al or A after I Dire d in by	Certification:	4 ☐ Homicide determined	build	ling, etc. (Specif	y)	,,		City or To	wn, State)	or or riare		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 ✓ Certifying P (Check only one)	miner: On the l	e best of my kno basis of examina oner stated.	wledge, deat tion and/or in	h occurred at the ti vestigation, in my	ce, and due to the	cause(s) and m	anner as s	stated. to the cause(s)		
	To the within To the	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed (Month, Day, Year)			
			Mishil eigh	D	D0064741 41				117/07				
	0	30. Name and address of person who completed cause of death (Item 23a) (Typ							. Itospit	(1) T		L ALL	
			31. Date filed (Month, Day, Year)	1 Will!	gistrar's Signa	ITRE de	LINCK M	MANAMA	1705/2 1	er, h	calit	ice, pool	
	Sta Registr		31. Date filed (Month, Day, Year)	2007	gistrar's Signa	B. 19	soule						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Michael April 10:40 AM Kenneth Denk 15 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Balti move HOSPITAL OF Bultimore CH 8. Date of Birth (Month, Day, Year) Tab. 3, 1952 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 ☑ M 2 □ F Hours Min. 55 218-56-0526 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43 Nantucket Drive 21904 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: ģ White 3 ☐ Widowed 4 ☑ Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Tidewater Marina Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Havre de Grace, MD Diesel Mechanic Twelve Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Denk Margaret Rupple ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Nichols 43 Nantucket Drive, Port Deposit, Maryland 21904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) New Bridge Baptist Church Cemetery 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/19/07 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. THE MM OPERryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** dan disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner RUS WHIM Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed outhy nidism 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has be rector, page 2 s autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending iniury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marginer stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 15, 2007

Registrar

State

Pallant

Sinai

MO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher

APR 17

2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-03063 State of Maryland / Department of Health and Mental Hygiene Michael Delomte Dorsey Certificate of Death Reg. No. 1- For State 3. Time of Death 2 Date of Death Registrar

1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 21, 2007 1835 hrs MICHAEL DELOMTE DORSEY Medir ⊂xaminer 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Charles La Plata 701 E. Charles St. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Hours Months Days Country) 06/13/1988 18 Director 1 XM 2 F Yrs 219-23-2936 Usual Residence of Decedent 10d. inside City Limits loc. City, Town or Location 10a. State 10b. County 1 X Yes 2 No LAPLATA CHARLES MD 28a-f show or items 23a or 28a-f show must be notified at once. 10g. Citizen of What Country Director 10f, Zip Code 10e. Street and Number UNITED STATES 20646 697 PISCATAWAY COURT 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Funeral White, etc. 11. Marital Status Armed Forces 1 X Never Married 2 Married 2 X No Yes BLACK Specify. Yes 2X No specify: f Yes, Give Yeer 4 Divorced 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done 2 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) NONE UNEMPLOYED 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROSSLYN KING ELROY F. DORSEY Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 697 PISCATAWAY CT., LAPLATA, MARYLAND 20646 ROSSLYN KING/MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) X Burial 2 Cremation 3 Removal from State ISSUE, MARYLAND 4/27/2007 HOLY CHOST CHURCH CEM Baltimo permit. Pages Department of Important: I Other Specify THYRNHON TONTÁE TOME, P.A. 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 21. Signature of Funeral Service Linensee LIDIA C. THORNION JOHNSON 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death edical Cardiac arrhythmia Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Cardiomegaly with biventricular hypertrophy and interstitial and Sequentially list conditions, replacement fibrosis Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - trans sician/Medical X UNPENDED 4#236-b,27,perME. g867. 5/10/07 TT ned by the attending physician detached for use as the burial -23d. Date of delivery The law requires that the death certificate be 23c. If yes, outcome of pregnancy Box 68760, Year Month Day 3 Ectopic pregnancy Fetal death 3b. Was decedent pregnant in the past 12 months Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Phy Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown Š 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy death? performed? certificate has No 1 🗸 Yes No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: funeral director, Other; Division of Vital Be Residence 6 V Other: Scene Hospital: DOA Nursing Home 5 ER/Outpatient 3 Inpatient this 1 ✓ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Yeer) 27. Manner of Death After Certification: 1 X Natural Yes 2 Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 • Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 22, 2007

State Registra

oho

Tasha Greenberg MD.

30. Name and address of person who completed cause of death (Item 23a)

2007

Assistant Medical Examiner

Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

07-03052 Ar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland	Department of He	ealth and	Mental Hygien

	4_6	State of Maryland / D	Certificate of	f Death	Reg	No.	ngh .
	Red	Decedent's Name (First, Middle,Last)	Oct into dio o	7 2000	2. Date of Death		3. Time of Death
Physician/ Examiner		Amy Catherine Destelho	orst		April 21, 20	07	1112 hrs
ZAGIIIIIO		Facility Name (if not institution, give street and number)		4b. City, Town, or Location o	f Death	4c. County of Death	٦
		510 Academy Street		Cambridge		Dorchester	10.1
Funeral	5.	Social Security Number 6. Sex 7. Age (In	n yrs. last birthday)		Min	(MM/DD/YYYY) 9. Bit Foreign	gn
Director		219-76-3550 1 M 2XF	35 Yr		Sept.	21,1971 co	ountry) MD
		sual Residence of Decedent					10d, Inside City Limits
any	10	a. State	c. City, Town or Loca		l = - =		1 X Yes 2 No
Show ad		MD Dorchester		Cambrid		g. Citizen of What Cou	
he Maryland tor 28a-f show iffed at once.	10	e. Street and Number		10f. Zip Code	10		and y :
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r death with or items 2: must be m	1	Never Married 2 Minarried 1 Yes 2X	No			Specify: W	hite
s after raff, o	, I	Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X No specify: ent's Usual Occupation (Give		16b. Kind of Business	/industry
natur Exam		15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)	during	most of working life. DO NOT	use retired)		
n 721 nan ", lical I		Elementary/Secondary (0-12) College (1-4 or 5+)	T T	waitress		restau	ırant
5-0036 led within 72 hours dygiene. other than "natur the Medical Exam	<u> </u>	7. Father's Name (First, Middle, Last)			r's Name (First, Middle, M	laiden Surname)	
215-0 be filed v mtal Hygi rked oth ent, the J		Robert Donald Destelhorst	Sr.	Do	orothy Helen	Gibson	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than re event, the Medica	1	9a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street and Nur			te, Zip Code)
and 2 shot lealth and 1 tem 27 is traumatic	-	Floyd Wade husband	510	Academy St.,	Cambridge,	MD 21613 20c. Location - City (Town State
more, MD 21 Pages 1 and 2 should nent of Health and Me ant: If item 27 is ma or other traumatic ev	2	0a, Method of Disposition	20b. Place of Disp	position (Name of cemetery,	Date	20c. Location - City (or Town, State
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Baltimore, permit. Pages 1 ar Department of He Important: If ite	2	Donation 5 Other Specify: 1. Signature of eral Service Licensee	22	2. Name and Address of Facili	^{ty} Thomas Fur	eral Home	P.A.
Dep Dep Initial	1	3a. Part I. Erier the disease, or complications that caused the		700 Locust St	Cambrido	re, MD 216	Approximate Interv
ysician	12	3a. Part I. Er or the disease, or complications that caused th failure. List only one cause on each line.	ie death. Do not ente	er the mode of dying, such as	cardiac or respiratory arr	est, snock, or near	Between Onset an
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death lent's Name (First Middle, Last) **Physician** Z 2001 /Medical Facility Name (If not institution, give street and numb own, or Location of Death 4c. County of Death Examiner Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 1**₽**M 2□F Months Days Hours Min. Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Ves 2 No Director MD LORE 10e. Street and Number 10g. Citizen of What Country? 5-14 12 MINGTON BLUD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 ☐ Divorced MITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5919 RAVEN DR. CHARLESTON SUNTER W.V. 25306 MELISSA DEEMER Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important; If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 5 Other (Specify) 22. Name and Addr ess of Facility 21. Signatur Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Part1. Enter the disease, or example shock, or heart failure. List only one Approximate Interval Bety Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes detached 9 Unknown 9 Unknown has been signed by citions contribution to death but not esulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ director, page 2 should be 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate the Hospital or Attending Physician; Be Was case referred to examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 201 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 Tyes 2 ∏ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, Name and add

State Registrar Day,

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07-02662 John Alan Eder

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		Registrar Certificate of Deat	th			Reg.	No.		
Physicia		Decedent's Name (First, Middle,Last)				Date of Death)- V		3. Time of Death
Medical Examir	ner	Jon Alan Eder				Month [April 7, 200]		ear	2208 hrs
*K		4a. Facility Name (if not institution, give street and number) 4b. City,	Town, or I	Location of	Death		4c. County	of Death	
		Baltimore Washington Medical Center Glen	Burnie				Anne A	rundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und	der 1 Year	If Under	24Hrs. 8	. Date of Birth	(MM/DD/YYY	Y) 9. Birth	place (State or
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any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits
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Aaryland 28a-f show 1 at once.	5	MD Anne Arundel Odenton							1 Yes 2 XX
Mary 28a-	Director	10e. Street and Number 10f. Zip	o Code			10g	. Citizen of V	hat Count	ry?
15-0036 filed within 72 hours after death with the Maryland I Hygiene. I other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once.	ਙੋ∣	515 Queen Anne Ave.	21.	113			U	SA	
with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decede					14. Rac	e - America	an Indian, Black,
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alt mit. partr port		21. Signature of Funeral Service Licensee 22. Name and	Address	of Facility	Harde	stv Fu	neral	Home.	P. A.
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24 h 24 h Fur	<u></u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the							
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in mand manner stated.			urred at the				
F \$ F 8	ž		c. License	e number		2	29d. Date sig	ned (Mont	h, Day, Year)
		Torshe Geer un	O.C.N	M.E.			April 8, 20	07	
	}	30. Name and address of person who completed ¢ause of death (Item 23a)							
10+1		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn S	Street, I	Baltimore	e, MD 2	1201			
	ate	31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	,	-		-			
Regist		31. Date filed (Month, Day, Year) ADD 1 3 2007 32. Fegistrar's Signature							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Vear **Physician** Evelyn D. Edwards April 2007 2100 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner Anne Arundel Medical Center **Annapolis** Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 □ M 2**X** F Director 214-26-0566 Dec 21 1931 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 232 Pindell Ave 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after of Hygiene. Hygiene. ther than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ò 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Crownsville State Elementary/Secondary (0-12) College (1-4or 5+) 12th Nurse Hospita1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John H. Wells Mary E. Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 Is any Injury or other tra Sandra Edwards(Daughter) 916 Bank St. Annapolis, Md. 21403 Date 20a. Method of Disposition 20c. Location - City or Town, State 20b Place of Disposition (Name of Benetato) Countainty or other place) 1 XBurial 2 □ Cremation 3 □ Removal from State Memorial Park 4-14-07 Annapolis, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee WinName Reddee of Cacilisons Mortuary, P.A. Zavry S. Reese Moo 483 821 West St. Annapolis,
23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive H Due to for as a consequence of disease or condition resulting in death) /Medical 1986 **Examiner** Oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death signed by the a 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune (Check only and manner stated. 29b. Signatuh and title of pertifier 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) Arnold, Wd. 21012 31. Date filed (Month, Day, Year) 1330 State 1 3 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Physician Month 3:13 Apri Anna Elizabeth Eigenbrode 700G /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Buttowere
If Under 1 Year | If Under 24 Hrs.
Days | Hours | Min. Sinai Hospita Bultimore 05 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director 84 216-16-4320 April 14, 1923 Maruland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 3 ☐ No Director Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America Completed by Funeral 7249 Andreus Road 21629 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, I Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be <u>Genevieve Maggie Stallings</u> ပ္ Fairfax Minor Miskell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Eigenbrode 7264 Andreus Road, Denton, Maryland 21629 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/19/2007 Denton, Maryland Concord Cemetery 22. Name and Address of Facility
Moore Funeral Home, i.A. 21. Signature of Funeral Service Licenses and ble -1/10 cu 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the dism'se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stage IV Over Due to (or as a consequence of): Ovarian Cancer rear /Medical Examiner Supplies

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner requires that the death certificate be executed the burial-trar Due to (or as a consequence of) Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) signed by the a 1 ☐ Yes 2 12 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by y pertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an page 2 s autopsy 2 A10 1□ Yes or Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 thpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Division or Attending 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No thours after death.

uneral Director: A death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled i Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Bulbimar mo Sadeka

DHMH 17-Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

APR 1 7 2007

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Anna

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Lester Andrew Fairgrieve 3:15 PM M April 20, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frostburg Frostburg Village Nursing Home Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 5, 1913 9. Birthplace (State or Foreign 217-10-5828 1 X M 2 □ F 93 Yrs. Director Aug. Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Modical Examinar main be notified at 10d. Inside City Limits MD. Allegany Lonaconing 1**X** Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17405 Lower Georges Creek Road 21539 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item eny injury or other traumatic event, the Madical Exertirations. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by F Specify: White 1 ☐ Yes 2XXIo Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fiber Manufacturer Machine Operator unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Fairgrieve Maude Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Kay Duckworth/ daughter 13301 Winchester Road, Cumberland, Maryland 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 04/23/ 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State Barton, Maryland Mt. View Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 7. Wun 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final OBSTRUCTIVE LUNCA, SEASTE **Physician** CHRONIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Esquertially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): use as the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ţō in the past 12 months? Day Month 4□Pregnant at time of death 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1□ Yes 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this After the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours efter death.

To the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02690 Hallon APRIL 20, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harjit Sidhu, 925 BISHOP Walsh Road, Cumberland, MD. 21502 31. Date filed (Month, Day, Year) APR 2 3 32. Registrar's Signature State 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 10:43 A^M Helen Rebecca Friend April 2007 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital 0akland Garrett If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔁 F Months Hours 3, Director Oct. Maryland 218-16-2623 Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Tyyes 2 □ No Director MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 E. Alder Street 21550 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked oth eny given or other traumatic event page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jessie George Woods Mary Catherine Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21550 Marion Caldwell, Niece 511 Main Street, Deer Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/16/2007 George Cemetery Swanton, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second Street, Oakland, MD 21550 usdo 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION **Physician** disease or condition resulting in death) 1 day /Medical Due to (or as a consequence of) Examiner atherosclerotic coronary artery disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? ğ page 2 should be diabetes mellitus type one 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes the Hospital or Attending Physician: hin 24 hours after death. ours after death.

neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ToF Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 1X X atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) April 14, 2007 D0025759 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter K. Naumann, M.D., PO Box 247, Accident MD 21520 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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Registrar

		-	For State Registrar	State of Marylan		artment of H		Mental Hygie	2007	13978
4	Physici /Medic		1. Decedent's Name (First, Middle, Last)	GEL	LM,	DN		2. Date of Death Month APRIL	Day 4, 200	3. Time of Death 7 11; 35 PM
Sugar	Examin	er	4a. Facility Name (If not institution, give si Hebrew Home of Gr	eater Washing		4b. City, Town, or Rockvi.	l1e		4c. County of Deal	omery
	Funeral Director		5. Social Security Number 6. Sex 214-03-4469 Usual Residence of Decedent	7. Age (In yrs. 9	last birthday) 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hr: Hours Mir		946 15 Co	hplace (State or Foreign buntry) SS14
	Maryland -f show fied at	tor	10a. State 10b. County Maryland Montgome:	D -	y, Town or Lo					10d. Inside City Limits
	h with the 23a or 28a at be noti	al Director	10e. Street and Number 6105 Montrose Road			10f. Zip Code 2085	52	10g.	. Citizen of What Co	
920	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or items 23a or 28a-f show event, the Medical Examinational to notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	ispanic Origin? (In, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
	filed within 72 he Hygiene. Nher than "natur ant, the Wedical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 Years		(Give life. L	lent's Usual Occupi kind of work done o DO NOT use retired Omemaker	ation during most of we d)	orking	o. Kind of Business Own Home	/Industry
land 2	outd be filed Mental Hygi arked other latic event, I	To Be Co	17. Father's Name (First, Middle, Last) Aron Gorelick					ame (First, Middle, Mai Hankin	iden Sumame)	
Mary	and and le m	6 8	19a. Informant's Name/Relationship (Typ	•	1			Rural Route Number, C	-	
Baltimore, I	00		David L. Gellman — 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	20b. P	lace of Dispo	sition (Name of natory or other place	e)	ney, Mary1 Date 2007	c. Location - City or	Town, State
Balti	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service License	Hottlemy	ch 11	70 Rockv	ille Pik	g Memorial ke, Rockvil	le, Mary	
100	rnysician /Medical Examiner	,	23a. Part1. Enter the disease, or compile shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	PRIER Directo (or as a consequence of the price of the p	uence of:	HYPC	g, such as cardia RTE1	V510N		Approximate Interval Between Onset and Death
8760, I	The law requires that the death certificate be executed the been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
.O. Box 6	it the death certifica by the attending ph tached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P	w requires that been signed b should be deta	5	Part II. Other significant conditions con	tributing to death but not resi	ulting in the u	nderlying cause give	en in Part I.	23e. Did tobad	1/	o the cause of death?
		Completed						24a. Was an autopsy performe 1 \(\text{Yes} \) 2	prior to	utopsy findings available completion of cause of
Vital	yeician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Oth	er A	eath (Check only one) Home 5 Residence	e 6 Oother (See	city)
ion of	ding Ph J. After th funeral	H-1	27. Many r of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe how		Glly)
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (Stree City or Town, S		ural Route Number,
	Vompletely filled in I	Medicai		ician: To the best of my kno er: On the basis of examina and manner etated.		vestigation, in my o	pinion, death occ	curred at the time, date	and place, and due	to the cause(s)
	3		· Bouleaux	2 follows	y M. L h(23a) (Type,	D. D.3	35430	5 A	PRIL 1:	th, Day, Year) 5, 2007 FMD 20952
			BARBARA KA	WINGH	1,61	21140	NTROS	15RD,Ra	CKVILLE	MD 20952
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 7 200	32 legistrar's Signa	ture /	sele)				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Year Timothy Michael Greenwell April 16 2007 5:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Calvert County Nursing Center Prince Frederick If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 1 X M 2 □ F Yrs July 9 1947 578-60-7679 Director 59 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Prince Frederick MD Calvert Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4270 Hallowing Point Road 20678 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) the Ř carpenter's helper construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 7 is marked of traumatic ever Alice Gert.rude Wilmer Greenwell Brady ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. Theresa Morcombe, niece 24242 Mallow Drive, Preston, MD 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Purial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 04-20-2007 Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20736 Rausch Funeral Home, PA Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 475 **Physician** 474 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hypertent/on the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes signed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 → es 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has certificate 2 No 1□ Yes 2 - HO 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation Injury nours after death.

neral Director: Ar
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a **To the Funeral I** Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)00 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 10 Hospital 32. Registrar's Signature 31. Date filed (Month) Day, Year) State APR 17 in the specie Registrar

Johnny Gibbs		State - For State	of Maryland	Departm Certific			and Me	ental Hyg			200	1 13	3981
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last	,			<u> </u>			Date of Death	Day	Year	3. Time of De	
Medical Examir		4a. Facility Name (if not institution, give	Johnny			b. City, Town,	or Locati	/	April 22, 20	007	unty of Death	2005 hr	S
and or Char		NorthWest Hospital	o otroot and mampor,			Randalist				1	more Cou	nty	
Funeral		5. Social Security Number 6. Se		e (In yrs. last bi	rthday)	If Under 1 Y		Jnder 24Hrs. Under 24Hrs. Win.	8. Date of Birtl	h(MM/DD/\	Foreig	า๋	- 1
Director		245-33-6060 1X Usual Residence of Decedent	M 2 F	41	Yrs.				July2	3,19	65 Co.	Mort]	Card
'any	ı	10a. State 10b. County		10c. City, Tow	n or Locatio	on				- N	,	10d. Inside (,
once.	ector		lington			Burl	ingt	ton	140		of What Cour	1 X Yes	2 No
ne Mary or 28a	Direc	10e. Street and Number 21 Threadleaf				10t, Zip Cod		24.6				try?	
n with the Maryland ms 23a or 28a-f show be notified at once.	al	11. Marital Status	12. Was Decedent				Hispanic	016 Origin? (Spec	ify Yes or No-		Race - Ameri	can Indian, Bl	ack,
or death	Funeral	1 X Never Married 2 Married		No				can, Puerto Ri	can, etc.)		White, etc.		i
urs afte	5	3 Widowed 4 Divorced 15. Decedent's Education (Specify or	if Yes, Give Year or Dates: ly highest grade com	npleted) 16a	. Decedent		pation (G	ive kind of wor			of Business/li		
6 172 ho	ete	Elementary/Secondary (0-12)	College (1-4 or 5		•	•		IOT use retired	1)		_		
5-0036 Iled within 77 Hygiene. I other than the Medical	Completed	17. Father's Name (First, Middle, Last)	5+		Linic	al Re		rcher	irst, Middle, M		Health	ncare	
21215 vuld be filed Mental Hy marked o	a		Johnny G	ibbs,	Sr.			Janio	e Har	dina			
D 21 should and Me 7 is ma	의	19a, Informant's Name/Relationship (T	ype, Print)	11	9b. Mailing	,		Number or Rur	al Route Num	ber, City o	r Town, State		0.700
e, MD and 2 sho Health and item 27 is	ŀ	Johnny Gibbs, Si 20a. Method of Disposition			46641 of Disposi	ISHig tion (Name of	cemetery	264-1	East V	Vasni 20c. Loca	Lngtor ation - City or	Town, State	.2/889
MOF Pages lent of lint: If		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:		210	atory or oth			04/2	8/07	Wach	ningto	Caro	lina
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ı			- Ce a	1a F _{22. N}	ame and Addr	ess of Fa						
Physician	\dashv	21. Signature of Funeral Service Licen Mulau 23a. Part I. Enter the disease, or comp	lications that caused	the death. Do r	not enter th	Hai e mode of dyi	rfor	d Road as cardiac or re	<u>d Balt</u> espiratory arre	Cimor est, shock,	ce,Mar orheart	ylano Approxima	22121 te Interval
/Medical Examiner		failure. List only one cause to ea	ch line. Cardiac arrh									Between C Dea	nset and
Zadimilei		or condition resulting in death)	Due to (or as a conse Tunneling o	equence of):				oalv					
	ner		Due to (or as a conse								•		
W8	Examiner	(Disease or injury that initiated C.	Due to (or as a conse	equence of):									
executed an and al - transit	dicalE	d. X UNPENDED	AMENDED										
sici be		IF FEMALE:	#23a-b,27,			10/07 <u>TI</u>	1			23d. Da	ate of delivery		
6876(certificate nding phy	cian/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at	time of death		al death	3 Ect	topic pregnanc	у	Moi	nth E	ay	Year
Box e death of the atten	Physic	1 Yes 2 No 9 Unknown	g Unknown		5 Oth	er (Specify)							
s, P.O. Bc irres that the dea ir signed by the a	by P	Part II. Other significant conditions	contributing to death	h but not resulti	ing in the ui	nderlying caus	se given i	n Part I.	parents		contribute to	page 17	
ds, Requires									24a. Was a	an j	24b. Were au	topsy findings	available
tal Records, cian: The law requi certificate has been : ector, page 2 should	Completed			_					autops perfor	med?	prior to c death? 1 🗸 Ye	ompletion of	No
tal Rec	Be Co	25. Was case referred to medical examiner?				26.PI		ath (Check onl					
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been seen in by the funeral director, page 2 should!	P.	1 Yes 2 No 27. Manner of Death	lospital: 1 Inpatie	ent 2 🗸 ER/0	Outpatient		Other	, maroing ,	Home 5 1	Residence		:	
on of anding Phath.	tion:	1 X Natural 5 Pending	(Month, Day,Y	rear)	. Time or it	' ' I _	Yes 2		ou. Describe in	iow injury c	ocurred		
ivision I or Attendi after death. Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not	28e Place of In	ijury - At home,	farm, stree	t, factory, office	e building	g, etc. 28	Bf. Location (S or Town, St		Number or Ru	ral Route Nur	nber, City
Divi	- 1	4 Homicide determined	10,000,000			1 10 0							
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b.	Medical	(Check only one) 1 Certifying Physici 2 Medical Examiner	 an: To the best of m On the basis of examination and manner stated. 										
F W W	Me	29b. Signature and title of certifier	and marrier stated.	1			ense num	iber		l	signed (Moi	nth, Day,Year)
		YVUI	DIN	1		0.	C.M.E.			April 2	3, 2007		
Ø		 Name and address of person who of Susan Hogan MD. Assistant 	completed cause of di stant Medical Ex			n Street, B	altimor	e, MD 2120)1				
	300	31. Date filed (Month, Day, Year) MAY 0 1 200		r's Signature	Rose	ونيو							
Regist	ıar	MINI O T 500) (January	D 50"	A CONTRACTOR	A DESTRUCTION OF THE PERSON OF					 		

State Registrar

C.VERGARA-SOARES

31. Date filed (Month, Day, Year)

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32. Segistrar's Signature

FRANKLIN SOUARE DR. BALTIMORE, MD 21236

		For State Registrar AMEND#4apenMD4,	/20/07, BMW, MbCc		artment of F rtificate of			g. No.		
Physicia /Medic	an	1. Decedent's Name (First, Middle, Last,		\sim			2. Date of Death Month April 14	Day	Year	3. Time of Death
Examine		4a Facility Name (If not institution, give Holy Cross Nursing	street and number) g and Rehab.	Center	Silver			4c. County		
Funeral Director		128-10-5649	7. Age (In)	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 12,		Coun	ace (State or Fore try) York
show	'n	Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo			·		10	0d. Inside City Lim
or 28e-f	Director	Maryland Montgome 10e. Street and Number	гу		10f. Zip Code	ng	10	g. Citizen of W	/hat Coun	
tural; or Items 23e or 28e-f show al Examinational be notified at	Funeral	1 Never Married 2 Married	ive 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give		Was Decedent of F	20905 dispanic Origin? (Sian, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race	- America k, White, e	
adia	Completed by	3 ■ Widowed 4 □ Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates:	16a. Dece	dent's Usual Occup	pation during most of wor	king	6b. Kind of Bu	WI	nite Justry
d other than svent, the N	Be	17. Father's Name (First, Middle, Last)	5+		Engineer	18. Mother's Nam	ne (First, Middle, M	U.S. Def		
and Men is marke sumatic	L C	Chester A. Harris 19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street		garet Jackso ral Route Number,		State, Zip	Code)
item other		Judy Myers - Daugh 20a. Method of Disposition 1 Burial 2 □ Cremation 3 1 □ Other (Specify)	200 lemoval from State	b. Place of Dispo cemetery, crer	sition (Name of natory or other place	April	19,	Oc. Location - (City or To	wn, State
Department of Importent: If any injury or once.		21. Signature of Funeral Service Licens		, 22 H	Memorial Name and Addre Ines-Rinal 1800 New H	ss of Facility		Pittsford r Spring		
	al Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Ceres (Final disease of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	Q S L V V sequence of):		I Sceik				Approximate Interval Between Onset and Death
Ph tr tr	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[Yes 2 \] No 9 \[Unknown \]	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnancy	1		23d. Date Mon	of deliver	ry Day Year
been signed b should be deta	þ	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	nderlying cause giv	en in Part I.				e cause of death?
has Je 2	Completed	•					24a. Was an autopsy performs	p: ed? di	rior to con eath?	sy findings availa pletion of cause
ect ect	Be	25. Was case referred to medical examiner?	lospital:		A OF BOA Oth	00	th (Check only one			
= 700	tion; To	27. Manner of Death 1 Matural 5 Pending	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time of	28c. Injur Wor	4 X Nursing H	ome 5 Residen 28d. Describe hov)
within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)			28f. Location (Stre City or Town,		or Rural	Route Number,
Funer Funer ely fill	dical	29a. Certifier 1 Certifying Physical (Chack only one)	sician: To the best of my larer: On the basis of exame and manner stated.	knowledge, death sination and/or inv	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	, and due to the cau rred at the time, dat	se(s) and mar e and place, a	ner as stand	ated. the cause(s)
within 2 To the complet	Me	29b. Signature and title of certifier	2008		29c. Licens 9605	4566	4	Date signed	7	
		30. Name and address of person who con Sun Hy Pho 9a V. 31. Date filed (Month, Day, Year) APR 1 7 20		OO-) (T				, -, -		

A	mended Item 1							_	_					
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	1 _ For State		State o	f Marylar	•					lental Hy	gier	ne "		, , , , ,
	Registrar				UE	ertificate	e or l	Jeatn			Reg. N	No.		
an	Decedent's Name (First, Mild:		, ice Ha:	rric						2. Date of De Month		Day	Year	3. Time of Death 7:45 а м
cal	4a. Facility Name (If not ins					4b City	Town or	Location	of Dogth	Apri.			007 y of Death	
ner	Carroll Luthe	_		lar	e Ctr			nster					rrol	L
	5. Social Security Number 219–20–3067	6. Sex	х]м 2)х F	7. Age (In yrs. 92	last birthday Yrs.	/) If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug 13	th ly, Yea	914	9. Birthp Cour Mary	
	Usual Residence of Decede													
	10a. State 10b. C	-		10c. Cit	ty, Town or I	Location							1	0d. Inside City Limits
cto	Maryland	Carro]						West	mıns	ter				1 X Yes 2 ☐ No
Sire.	10e. Street and Number					10f. Zip	Code				10g. (Citizen of	What Cour	ntry?
ai	201 St. Marl	k Way i	#308					21	158			US	A	
Jue	11. Marital Status		12. Was Dec Armed Fo	edent Ever in U proes?	.S. 13	. Was Deced If Yes, spec	ent of Hi ify Cuba	spanic Or n, Mexicai	igin? (Sp	ecify Yes or No Rican, etc.))-		ce - Amend	
Be Completed by Funeral Director	1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify:										nite			
etec	15. De (Specify only	cedent's Edu	cation e completed)		16a. Dec	edent's Usua	I Оссира	ition lurina mos	t of work	ina	16b.	Kind of B	usiness/In	dustry
ompi	Elementary/Secondary (0	T	Cotlege (1-4or 5+)	life.	re kind of wor DO NOT us Teacl)				Scho)	
0	17. Father's Name (First, M	iddle, Last)			,			18. Moth	er's Name	e (First, Middle	Maide	en Suman	пе)	
To B	Harry P	rice_	Hen	ry Pric	ee				Ethe	el R. W	nee.	ler		
	19a. Informant's Name/Rel	ationship (Ty	rρe, Print)							al Route Numb				
	Amber D. Cu	rtis,	attorn	ey	127	E. Ma.	in S	treet	·, We	estmins	ter	, MD	21157	7
	20a. Method of Disposition 1 Burial 2 □ Crem	ation 3 🗆 🗆	lemoval from		Place of Disp cemetery, cr	oosition (Namematory or of	e of her plac	9)	ſ	Date	20c.	Location	- City or To	wn, State
	4 Donation 5 Ot			Be	niami	n's (K	ride	rs))4/18	3/2007	Ţ	Westn	ninste	er, MD
	21. Signature of Funeral Se	rvice License	өө МО	1191 [22. Name and	d Addres	s of Facili	,					eral Home
(Justin +	<.7	Junt	سس						Westmir		er, M	D 211	57
\	23a. Part). Enter the disea shock, or heart failure	se, or compli . List only or	ications that one cause on e	caused the deat each line.	h. Do not e	nter the mode	of dyin	g, such as	cardiac	or respiratory a	rrest,			Approximate Interval Between
	Immediate Cause (Final disease or condition		Al.	zhoin	1500	s do	m	tone	i Ca					Onset and Death
	resulting in death)		Due to	(or as a conseq	uence of):					. 1				
	Sequentially list conditions	t	ce.			colux	1	Jee'	ille	· m				
ine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	~	Due to	(or as a conseq	uence of):									
хап	that initiated events resulting in death) Last	0	C	(or as a conseq	uanco of):									
a E			Due to	(or as a conseq	derice or).									
dic			d											
hysician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnain the past 12 months 1 Yes 2 No 9 Unknown	THE	1☐Live t	tcome of pregna birth 2 Teta nant at time of d own	t death 3	□Ectopic pre							ite of delive	ory Day Year

Physician /Medical Examiner

Physic /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the turneral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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	Immediate Cause (Final disease or condition resulting in death)	a. Alzheimez Due to (or as a consequence of)	's demention		5-10 1/2
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cerobro VN Due to (or as a consequence of) Due to (or as a consequence of) d.	soulur Aesid	· tr	
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 5 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetat death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
ed by Ph	Part tl. Other significant conditions co	ntributing to death but not resulting in th	e underlying cause given in Part I.		use contribute to the cause of death?
Complete				24a. Was an autopsy performed?	24b. Were autopsy findings availabed prior to completion of cause of death? 1 ☐ Yes 2 🕱 No
Be (25. Was case referred to medical		26. Place of De	ath (Check only one)	
10	examiner? 1 ☐ Yes 2 1 No	Hospital:	04	dome 5 ☐ Residence	6 DOther (Specify)
atlon: T	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. Injury at	28d. Describe how intu	
Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnjury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, 3)
edical	29a. Certifier (Check only one) 2 Medical Exami	sician: To the best of my knowledge, diner: On the basis of examination and/cand manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	e, and due to the cause(s urred at the time, date and) and manner as stated. d place, and due to the cause(s)
Σ	29b. Signature and title of certifier		29c. License number		te signed (Month, Day, Year)
	> Obening	Jumo	D 5170 9	5 4	t-16-07
	30. Name and address of person who come PANSURIYA	-Δ. ΔΔ.	w/m DR, We	otminste	2 MO 21157
ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature			
ar	APR 17	2007 Glosun &	Sperk		
001			1		

DHMH 17 Rev 1/2001

State Registrar

WIL 10

Amended Item 26 per Physician 04/16/2007 Carroll County, wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Verna Lee Hollingsworth 4 14 P_{\bullet}^{M} 2007 9:25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Dove House Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Months Days Hours Min. 215-34-0748 70 Director 12/13/1936 TN Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State a or 28a-f show be notified at Hampstead Carroll 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21074 United States ns 23a (must b 3195 Shamer Lane Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 💢 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked of traumatic even Anna Lois Dowdy Rev. Clarence Broyles 19a. Informant's Name/Relationship (Type. Print)
Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Charles Hollingsworth Department of Health Important: If item 27 any injury or other troonce. 3195 Shamer Lane Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/18/2007 Hampstead, Maryland Hampstead Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Eline Funeral Home, 934 South M001490 Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AcusE KESPIRATURY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2**X** No HEART 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown CONGERTIVE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ELCEPHRLOPATITY perfor 1∐ Yes DIABETES 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 4☐ Nursing Home 5☐ Residence 6 MOther (Specify) Hospice Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

The law requires that the death certificate be executed attending physician and for use as the burial-transi Division or Vital Records, P.O. Box 68760, been signed by the should be detached Hospital or Attending Physician: after death.

Director: After this certific filled in by

the Maryland

filed within 72 hours after death

Pages 1 and 2 should be f nent of Health and Mental I ant: If item 27 is marked o

Baltimore, Maryland 21215-0036

show

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To the I

VINCERT 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mocco To

29c. License number DO 1663 29d. Date signed (Month, Day, Year) 4/16/07

447 E. MAIN

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32. Registrar's Signature

APR 1 6 2007

Registrar

			For State Registrar	State of Ma	-		cate of l		мента пу	Reg. No	711111	13986
r	Physicia	ın	1. Decedent's Name (First, Middle, La.	st)					2. Date of De Month	eath Da	ıy Year	3. Time of Death
157	/Medic		Kenneth E.		Hetrick				April	8	2007	9:10 A ^M
1	Examin	er	4a. Facility Name (If not institution, giv	,		4b.	City, Town, or	Location of Deatl	1		c. County of Dea	
		u.	Genisis at Colle 5. Social Security Number 6. S	-	e (In yrs. last bir		rederio Under 1 Year		8. Date of Bi			Frederick
L	Funeral Director			M 2□F			nths Days	Hours Min.	April 7	ay, Year		thplace (State or Foreign ountry) yland
	anyland show d at	_	10a. State 10b. County		10c. City, Town							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he Ma Ba-f	ecto	MD Frederi	.ck		Frede						
	h with the 3a or 2	i Dire	10e. Street and Number 1336 Taney Ave.,	Apt 202		110	of. Zip Code 217()2		_	itizen of What Co JS	ountry?
336	be filed within 72 hours after death with the Maryland ital Hygiene. Adother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at event,	by Funeral Director	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates!	No	1 1 1	Decedent of H s, specify Cuba es 2 X No	ispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: W	e, etc.
21215-0036	within 72 hou ene. than "natur he Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation	16a.	Decedent's (Give kind life. DO N		during most of wor i)		16b. k	Kind of Business	/Industry
		ပ္ပံ	8		Fe	deral	Police	Officer			zernment	al
and	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last,					18. Mother's Nar			n Surname)	
7	d 2 should be filed th and Mental Hygi 7 is marked other traumatic event, the	ဥ	Harvey L. Hetric 19a. Informant's Name/Relationship (10h	Mailing Ad	drass /Ctrast	Ruth and Number or Ri	Brenne		or Town State	Zin Codo)
Maryland	d 2 s th ar 7 is trau		Margie L. Hetric	**				e., Apt 2				21702
Baltimore,	es 1 a of Hee		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	20b. Place of cemete.	f Disposition ry, cremator	(Name of ry or other place	ce)	Date	20c. L	ocation - City or	Town, State
altim	permit. Pag Department Important: I any Injury o once.		4 □ Donation 5 □ Other (Specification 21. Signature of Fundal Service Lice		Locust			ery Apr ss of FacilityBur		_	Mt. Airy Funeral	•
8	e a E e		John Kel	Br.		1212	West (old Liber	tv Road	L. Wi		MD 21784
	Physician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each ling a	the death. Do ne.	not enter the	e mode of dyin	g, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (of its	a consequence	Telh'	tus					YGARS
	ecuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Hy	a consequence hwten	ion						YEARS,
68760,	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (of As	a consequence	of):						
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.O. Box	The law requires that the death cert ate has been signed by the attending rage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		pic pregnancy er (specify)				23d. Date of de Month	livery Day Year
rds, P.	igne be d	کِ	Part II. Other significant conditions	contributing to death b	ut not resulting in	n the underl	ying cause giv	en in Part I.			use contribute to 2□ No 3□ P	o the cause of death? robably 4 Dunknown
Vital Records,		Completed							24a. Was auto perf 1□ Yes	an ppsy ormed? 2010	prior to death?	utopsy findings available completion of cause of
Vita	iclan certifi ector	Be	25. Was case referred to medical examiner?	Hospital:			□ no. Oth	26. Place of Dea				
0	Phys ral dir	2	1 ☐ Yes 2 ☐ No 27. Manne of Death	28a. Date of Inju		tpatient 3	L DOA	4 LawNursing F	lome 5 ☐ Res 28d. Describe		6 □Other (Spe	ecify)
ion	ath. r: After re funer	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da		Injury	28c. Injur Wor 1 □	yes Yes 2 □ No	Zod. Describe	HOW HIJ	ary occurred	
Division	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director,	Certification:	3 Suicide 6 Could not b determined	28e. Place of injuding, et	ury - At home, fa	arm, street, t	actory, office		28f. Location (City or To	(Street a wn, Sta	nd Number or R te)	ural Route Number,
	To the Hospital c within 24 hours af To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exam	nysician: To the best miner: On the basis o and manner st	f examination ar	e, death occ nd/or investi	urred at the tirgation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time	e cause(, date a	s) and manner and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	M	29b. Signature and title discertifier	•			29c. Licens			29d. D	ate signed (Mon	th, Day, Year)
	14						D006	1223		4	110/07	
	BTILA		30. Name and address of person who PRAVEEN BOL	completed cause of d	eath (Item 23a)	(Type, Print	IOLI R	AD PR	KOERICE	K, M	10217	03.
474	Sta Registr		31. Date filed (Month, Day, Year) APR 1.3	32. Registr	ar's Signature					-/		

Amended Item 22 per F.D. 04/11/2007 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Donald Joseph Hebert 09 2007 12:10p^M April */Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Westminster Carroll Hospital Center Carroll 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2 □ F **Director** 438-10-6700 84 Feb 10 1923 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Carroll 1 ☐ Yes 2 ☑ No Finksburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Lassiter Circle 21048 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify þ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Deli Manager Pantry Pride 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Hebert ဂ Aliada Hebert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Linda Szymanski/Daughter 7003 MacBeth Way Sykesville, MD21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/11/2007 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Cremation, Inc Hampstead, MD ature of Funeral Service Licens Pricts Funeral Home and Chapel, P.A. 2 Washington Rd Westminster, MD 21 A50 oximate Interval Between Onset and Death 23a. Prt1. Enter the disease, or complications and a used the death. Do not effect shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) MO /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Oue to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of prior to completion death?

1 Yes 2 No autopsy performed? (es 2 \(\subseteq \text{No.} \) certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Impatient 2 ER/Outpatient 3 DOA this After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title 29d. Date signed (Month, Day, Year) WJZ 10 s of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar 2007

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 14,2007 Year **Physician** 11:20p M Phillip Henry Hartley, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. March | 17, 1950 Union Hospital Cecil 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 216-54-3329 57 MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits items 23a or 28a-f show her must be notified at 1 ☐ Yes 2X No Director MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 73 Old Chestnut Rd. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

**Miles 2 in No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. ant If Item 27 is marked other than "natural", or iten uny or other traumatic event, the Medical Examineatury or other traumatic event, the Medical Examineatury or other traumatic event, the Medical Examineatury or other traumatic event, the Medical Examineatury or other traumatic event, the Medical Examineatury and the Medical Examineatury or other traumatic event, the Medical Examineatury events and the 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1968 1 ☐ Yes 2 No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amy L. Diehl Louis A. Hartley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 73 Old Chestnut Rd., Judy Hartley/Wife Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot once. April 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State North East Cemetery 4 ☐ Donation 5 ☐ Other (Specify) North East, MD 2007 21. Si nature of uneral service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21 0 2 1 Approximate Interval Between Onset and Death Immediate Cause (Final Infarction Physician Acute Myoccidial disease or condition resulting in death) /Medical Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 No 2☐No 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10-52087 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 BOW ST. EIKtON MO Piarulli 5 MO chiel 32. Registrar's Signature Year) 31. Date filed (Month. State Registrar

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			1 - For State Registrar	State of Marylan		-	te of Deat		-	Reg. No.	U07	139	89
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ath	V	3. Time of D	eath
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	Funeral Director		5 Social Security Number 6. Sex	7. Age (In yrs.	last birthd Yrs	Month:			8. Date of Birt (Month, Day	y, Year)	Co	nplace (State or F untry) hington,	-
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	anylan ahow	_	10a. State 10b. County			r Location						10d. Inside City	
\bigcirc	Ba-f	Director	Maryland Dorchester	Hu	rlock		T- 0-4-			10- 014-			
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ō	g Phy er this eral d	n; To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tim	e of	28c. Injury at Work?		28d. Describe h			any)	
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			31 Date filed (Month Day Year)	32. Regis ar's Signa 2007	fure.	RN S	T CKMI	12 KING	5 mg	2161	3 (416) 221-7	1770
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			For State Registrar	State of Mi	aryland		rtificate of		vientai m	Reg. No.	Pr. 13 - 1	13990
	Physici	an	1. Decedent's Name (First, Middle, La	st)					2. Date of D Month	eath Day	Year	3. Time of Death
jā.	/Medic		James Bra	dford Hors	ey				April	17	2007	4:58 A ^M
	Examin	er	4a. Facility Name (If not institution, giv	,				r Location of Death	1		County of Death	
			5. Social Security Number 6. S		je (In yrs. las	t birthday)	Denton If Under 1 Year	n If Under 24 Hrs.	8. Date of B	irth	Caroline 9. Birth	2 place (State or Foreign
6.0	Funeral Director			⊠M 2□F	71	Yrs.	Months Days	Hours Min.	June	ay, Year)	Cot	nyland
	rland ow at		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Man a-f sh filed	ţċ	Maryland Carol	ine	Den	ton						1√EYes 2 No
	th the or 28% e not)irec	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Cou	intry?
	ath wi 23a o ust b	Funeral Director	9 South Sixth Str	reet			21629					es of Americ
	or des tems ter m	nue	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of H If Yes, specity Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	lo-	 Race - Amer Black, White 	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. It health and marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		1 ☐ Yes 2 ☑ No	Specify:			Specify: Cau	casian
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d 21	filed withi Hygiene. ther than		12. Father's Name (<i>First, Middle, Last</i>)		Ource	ou operaci	18. Mother's Nan	ne (First, Middl			mace
an	d be ental ked o	To Be	Daniel Ras					Manu	Southon	Shan	n	
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ore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 ☐	The second from Chate	20b. Plac	ce of Disponetery, crei	sition (Name of matory or other plac	ce)	Date		cation - City or 7	
<u>ii</u>	mit. Pages artment of hortant: If the injury or of e.		4 □ Donation 5 □ Other (Special		Cap	itol	Cremator	y 4/18	3/2007	Dov	er, Deli	mare
Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service Lice	Mode		22 /*	2. Name and Addre	ss of Facility eral Home	P.A.	nonto	n Marin	land 21629
	- 00		23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that cause	d the death.	Do not ent	er the mode of dyir	ng, such as cardia	or respiratory	arrest,	n, Kary	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	a Metau	1		Male					Onset and Death
)	/Medical		resulting in death)	Due to (or as			VIII	Canu				1 years
8	Examiner		Sequentially list conditions	b								•
	D ##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	nce of):						
	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consenue	nce of).			<u></u>			
60,	be es iician buria			2 40 10 (0. 40	a 551,554,55							
68760,	ficate physis the	edical		d								
Box	death certi attending		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnanc		7			1	23d. Date of deli	very
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4☐Pregnant a			□Ectopic pregnancy □ Other (specify) _	/			Month	Day Year
P.0	The law requires that the death cer to has been signed by the attendin bage 2 should be detached for use	Physician/N	9 🗆 Unknown	9□Unknown								
	res tha signed b	by F	Part II. Other significant conditions	contributing to death b	out not resulti	ng in the u	nderlying cause giv	en in Part I.				the cause of death?
ord	w require been sign	ted							1] Yes 2[□ No 3 □ Pro	obably 4 Unknown
Records,	ie law r has be je 2 sh	Completed							24a. Wa aut	onsv	prior to c	topsy findings available ompletion of cause of
al H		S							per 1□ Yes	formed? 2 No	death? 1 ☐ Yes	2□ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	28. Place of Dea	ath (Check only		Homa Oc	n Harriso
o	Phys this al di	T ₀	1 ☐ Yes 2 XNo 27. Manner of Death	28a. Date of Inju		R/Outpatier 8b. Time o		4 Li Nursing F	lome 5 ☐ Re		o the spec	ity) respecte
	ling After fune	ion	1 Naturat 5 ☐ Pending	(Month, Da	y Year)	Injury	Wor	yai k? Yes 2 ∐ No	28d. Describe	e now injur	y occurred	
Division	Attend death ctor:	ficat	3 Suicide 6 Could not b	e 28e. Place of inj		e, farm, str	eet, factory, office	100 2 110	28f. Location	(Street an	d Number or Ru	ral Route Number,
Ö	Hospital or Attending 44 hours after death. Funeral Director: After tely filled in by the funer	Certification:	4	building, e	tc. (Specify)					own, State		
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the i	Medical	29a. Certifier (Check only one) Certifying Pl 2 Medical Exa	nysician: To the best miner: On the basis o and manner st	of examinatio	edge, deat n and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	e, and due to thurred at the time	e cause(s) e, date and) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the complet	ğ	29b. Signature and title of certifer				29c. Licens	e number	-	29d. Dat	te signed (Month	o, Day, Year)
	/		30. Name and address of preon who	completed cause of a	leath (Item 2	3a) (Tvne		- 0 -			1./2	/
			Korah Pulimood, P	1.D. 912 1	Market	Stre	et. Dente	on, Maryl	and 21	529		
Α.	Sta Registi		31. Date filed (Month, Day, Year)	32. Registr	rar's Signatu	re	nells					
	negisii	uı	PR 1 7 21	JU/	Se S	6	Dec. J					

DHMH 17 Rev 1/2001

			For Stete Registrar	State of M	laryland	•	artment <i>rtificate</i>				-	giene Reg. No	11117	13991
			Decedent's Name (First, Middle,	Last)							2. Date of De	ath		3. Time of Death
	Physici /Medic		William Raymond .	Joyce, Jr.						A	April 1	17,	2007 Year	9:15 AM
	Examin		4a. Facility Name (If not institution,		•)		4b. City, T			of Death			County of Death	
			3700 Blackthorn (Chevy						ontgomer	
H	Funeral Director		103-22-7234	.Sex 7. A	ge (In yrs. Ia 85		If Under 1 Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da May 18	th 19, Year) 19.	21 New	place (State or Foreign intry) York
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Maryi f sho	Į.	MD Montgo	ne r v	Chev	y Chas	20							1 XYes 2 □ No
	r 28a	rec	10e. Street and Number	ner y	Onev	y onat	10f. Zip (Code				10g. Cit	tizen of What Cou	untry?
	h with	al D	3700 Blackthorn (Court			2081	.5				USA		
36	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 'I is marked other than "natural", or Itams 23a or 28a-f show raumatic event, it e Madical Examinatin wat be notified at	y Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Armed Forces 1 Yes 2 2	7		Was Decede f Yes, speci	ty Cubar	spanic Ori n, Mexican Specify:	i, Puerto P	cify Yes or No Rican, etc.))-	14. Race - Amer Black, White Specify: T.Tle	, etc.
ğ	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	:	12. 5	ticale to					100	WI	ite
ب	n 72 nat	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual kind of work DO NOT use	done di	urina mosi	t of workin	g	16b. K	(ind of Business/I	ndustry
72	withi	duc	Elementary/Secondary (0-12)	College (1-4or 5+		Attori		, , , , ,				Law		
2	Hygi Other ent	Be C	17. Father's Name (First, Middle, La						18. Mothe	er's Name	(First, Middle,	, Maiden	Sumame)	
<u>lan</u>	uld be Aenta rked tic ev	To B	William R. Joyce	, Sr.				V	Vinif	red 1	Lowery			
	nd 2 sho alth and N 27 is ma r trauma		19a. Informant's Name/Relationship Mary—Hoyt S. Joye				ng Address Black						or Town, State, Z se, MD 2	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 4 ☐ Donation 5 ☐ Other (Spe		e ce	ace of Dispo metery, crem sapeal	natory or other	her place		04/18	ate 8/07		ocation - City or T	
Balt	permit. I Departm Importal any inju		21. Signatur Funeral Servide Li		t wo1								P.O. Bo	
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that cause	d the death.	Do not ent	er the mode	of dying	HECK , such as	cardiac or	respiratory a	rrest,	arksvili	e, MD 21029 Approximate
	Physician		Immediate Cause (Final											Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Myocardi Due to (or as			Lon							Immediate
	Examiner		0	b Ischemic	Card	iomvor	nathv							5 years
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequ	ence of):								
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с										
Ĉ,	licate be executed physician and s the burial-transit	E	resulting in death) Last	Due to (or as	s a consequ	ence or):								
8760	cate l physi the b	dlcal		d										
O. Box 6	ath certii attending for use a	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□ Unknown	2 Fetal	death 3	Ectopic pre Other (spe						23d. Date of deliver Month	very Day Year
٦.	hat the de d by the detached	Phy	Part II. Other significant condition	e contributing to death	but not recu	Iting in the u	adorhijaa oa	uco anto	n in Part I		23a Did t	obacco	usa contributa to	the cause of death?
Records,	w requires that been signed I should be det		Tarrii. Othor significant contanton		Dut 110t 163u	ining in the di		uso givo						bably 4 Unknown
	The law rate has be page 2 sh	Completed									24a. Was autor perfo		prior to c death?	opsy findings available ompletion of cause of
Vita		BeC	25. Was case referred to medical						26. Place	of Death	(Check only o		<u> </u>	
	hysic his ce I direc	To	examiner? 1 ☐ Yes2 🏋 No	Hospital: 1 Inpati	ient 2 🗆 E	ER/Outpatien	t 3 DO	Othe	r: 4□ Nu	rsing Hom	ne 5 ⊠ Resi	dence	6 □Other (Spec	ify)
o uo	nding Phy tth. :: After thi e funeral		27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inj (Month, Date)	ury ay Year)	28b. Time of Injury	28 M	lc. Injury Work 1 Y	at ? ′es 2 □ I		8d. Describe	how inju	ry occurred	
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 286, Place of In	njury - At hor atc. (Specify)	me, farm, str	eet, factory,	office		2	8f. Location (City or To			ral Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the best taminer: On the basis of and manner s	of examinati	vledge, death ion and/or inv	occurred a vestigation,	t the time	e, date an inion, dea	id place, a	nd due to the d at the time,	cause(s date and	and manner as d place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	.1 1		4. k		License	number			29d. Da	ite signed (Month	, Day, Year)
			* Klern o	Nealo	m,	M.D	D2	3127	7		A	Apri	1 17, 20	07
)	Im		30. Name and address of person will Kevin G. Nealon,	no completed cause of	death (Item			Suite	925	Che	vy Chas	se, l	MD 20815	
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 8	32. Parist	trar's Signat									

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryla		artment of rtificate of		Mental Hygie		, 5556
	Physici		Decedent's Name (First, Middle, Last MARTHA V. JAC					2. Date of Death Month APRIL	15 2007	3. Time of Death 4:20 P M
	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of Death	1.20 1
			HARFORD MEMORIA				AVRE DE G		HARF	ORD
	Funeral Director		5. Social Security Number 6. Se 219–80–1192 Usual Residence of Decedent	x 7. Age (In yrs	s. last birthday) S Yrs.	Months Days		8. Date of Birth (Month, Day, Ye FEB 13,	9. Birthp Cour 1912 MA	place (State or Foreign htry)
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation			1	0d. Inside City Limits
	e Mar	Director	MARYLAND HARF	ORD		HAVR	E DE GRAC	E		1 XYes 2 □ No
	with th		10e. Street and Number	YIII) EVENT		10f. Zip Code	21.070	10g.	. Citizen of What Cour	ntry?
	Death me 23	Funeral	415 S. MARKET S	12. Was Decedent Ever in	U.S. 13.	Was Decedent of	21078 Hispanic Origin? (Si	pecify Yes or No-	USA 14. Race - Americ	an Indian.
920	72 hours after death with the Maryland "natural", or Itema 23a or 28a-f show idical Examinational Bancilliad at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No ff Yes, Give Year or Dates:		if Yes, specify Cul 1 □ Yes 2 🖾 No	Hispanic Origin? (Span, Mexican, Puerting Specify:	o Rican, etc.)	Black, White, Specify: BLAC	etc.
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occu	pation during most of wor	kina 168	b. Kind of Business/In	dustry
121	d within piene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire HOMEMAKE	ed)		OWN HOME	
1d 2	F F F	Be Co	17. Father's Name (First, Middle, Last)					ne (First, Middle, Mai		
ylar	should be nd Mental marked o umatic eve	ToE	LAURE JACKSON				HALLIE	TAYLOR		
Maryland 21215-0036	~ 4 = =		19a. Informant's Name/Relationship (Ty WILLIAM SMITH / C	pe, Print) OUSIN					ity or Town, State, Zip	
	Heelth tem 27 other tr		20a. Method of Disposition		Place of Dispo	sition (Name of			MARYLAND Location - City or To	
E C	Peges nent of ant: If it		1 M Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	temoval from State		natory or other pla			CHURCHVILL	
Baltimore,	permit. Peg Department Important: I eny injury o once.		21. Signature of Funeral Service Licens	tt-colomo		Name and Addr	OTT FÚNER	AL HOME, I		
68760,	Medical Examiner bhysicien and sthe burial-transit	edicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	quence of):	VE CD			winze	
P.O. Box 68	death certii e ettending ed for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2/4 No 9 ☐ Unknown	3c. ff yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □	Ectopic pregnand Other (specify)	у	F.381	23d. Date of delivery Month Day Year	
	quires thet the n signed by th uld be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
of Vital Records,	The law requires sete hes been sign page 2 should be	Completed			- 6-5-	24a. Was an autopsy performed	prior to cor	psy findings available inpletion of cause of		
Vita	Phyelclan: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		10		th Check only one	-	
ō	d s	. To	1 Yes 2 No	28a. Date of Injury	ER/Outpatien 28b. Time of	I JU DON		ome 5 Residence	e 6 ☐Other (Specify	′)
<u>o</u>	Attending r death. ctor: After by the fune	atior	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	28c. Inju Wo M 1	rk?]Yes 2∐No		.,_,	
Division	tal or Atters setter de al Directo	27. Manner Pleath 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 9. Place of Injury - At home, farm, street, factory, office 28t. Location (Street and houiding, etc. (Specify) 28b. Time of Injury at Work? 28b. Time of Injury at Work? 1 Yes 2 No 28b. Injury at Work? 1 Yes 2 No 28b. Describe how injury of Injury at Work? 28b. Describe how injury of Injury at Work? 28b. Describe how injury of Injury at Work? 28c. Injury at Work? 28b. Describe how injury of Injury at Work? 28c. Injury at Work? 28b. Describe how injury of Injury at Work? 28c. Injury at Work? 28b. Describe how injury of Injury at Work? 28c. Injury at Work?								l Route Number,
	To the Hospital or Attending Phwithin 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) Certifying Physical Examination)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the to restigation, in my	me, date and place, opinion, death occur	and due to the causi red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier	A Guard	O HIL	29c. Licen.	A . /	- 1	Date signed (Month,	Day, Year)
	2		30. Name and address of person who go	BIONNO	m 23a) (Typer	Print) 3/9	South	ONIN A	16/16/6	Mon
	Sta Registr		31. Date filed (Month, Day, Year) APR 1:7 2007	32. Registrar's Sign	ature	11		- 77	/	21078

Jackson, Martha

		State of State Registrar		artment of He rtificate of D	alth and Mental Hy eath	/giene Reg. No. 007 13993
Physicia /Medic	ăl	1 Decedent's Name (First, Middle, Last) Edward Haz		ckson	2. Date of D Month Apri	Day Year
Examine Funeral Director		4a. Facility Name (If not institution, give street and number Chesapeake Woods 5. Social Security Number 6. Sex 7.		If Under 1 Year	oridye	Dorche Ster rth ay, Year) 9. Birthplace (State or Foreign Country)
h the Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County MD Dorche Ster	10c. City, Town or Lo	oridge		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ath with the	Funeral Director	815 Park Lane		10f. Zip Code 2 /6		10g. Citizen of What Country?
5-0036 72 hours after des	þ	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give Year or Date	₽No	_	nanic Origin? (Specify Yes or N Mexican, Puerto Rican, etc.) Specify:	o- 14. Race - American Indian, Black, White, etc. Specify: BlacK
24 ti # # # # # # # # # # # # # # # # # #	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	or 5+)	edent's Usual Occupation in the second of work done during the DO NOT use retired)	on ring most of working	16b. Kind of Business/Industry Methodist Church
be od o	To Be C	17. Father's Name (First, Middle, Last) Charles Jacks			8. Mother's Name (First, Middle) Martha 5	tanley
Ore, Notes that to the title m 27 or other tr		19a. Informant's Name/Relationship (Type, Print) E	724 20b. Place of Disponsion o	osition (Name of omatory or other place)	nt Ave. Cam	or, City or Town, State, Zip Code) or, dee, Mary and 3/6/3 20c. been on - City or Town, State
Baltimore, permit. Peges 1 a Department of Hes Importent: If item any injury or othere.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Rucktown	V CAMETER 2. Name and Address 1 - Name and Address 5 10 Wash	of Facility Fac	Cambridge, Maryland 1. ubridge, MD. 21613
Playsician /Medical Examiner his prival transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ised the digith. Do not enoth fine.	tery di ture	such as cardiac or respiratory	Approximate Interval Between Onset and Death 10 years 3 years
I Records, P.O. Box 68 The law requires that the deeth certification has been signed by the ettending phyage 2 should be detached for use as the	by Physician/Med	23b. Was decedent pregnant 1 Live birt	nt at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Cords, P.O. w requires that the been signed by the should be detached.	ed by Ph	Part II. Other significant conditions contributing to dea				tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Vital Records, sician: The law requires to certificate has been signe rector, page 2 should be controlled.	Completed	sick sinus s	yndrome		24a. Wa aut per 1 🗆 Yes	opsy prior to completion of cause of death?
of Vital Physician: The Physician: The this certificate ral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Ing	patient 2 ER/Outpatie	Other	26. Place of Death Check only 4. Nursing Home 5 - Re	
Jing After fune	atlon: To	27. Manner of Death 28a. Date of		of 28c. Injury a Work?		how injury occurred
	Certification:	3 Suicide 6 Could not be 28e. Place o	f Injury - At home, farm, st j, etc. <i>(Specify)</i>	treet, factory, office	28f. Location City or T	(Street and Number or Rural Route Number, own, State)
Di Hospitel or 24 hours after Funerel Dir etely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner.	is of examination and/or in	ith occurred at the time nvestigation, in my opin	, date and place, and due to th nion, death occurred at the time	e cause(s) and manner as stated. b, date and place, and due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License i		29d. Date signed (Month, Day, Year)
		30. Name in address of person who completed cause		, Print)	059973	4/12/07
Sta Registr		Patricia Johnson, DO 31. Date filed (Month, Day, Year) APR 1 3 2007	100 Bramble trar's Signature	2017	idge, MD	

State Registrar

DHMH 17 Rev 1/2001

CINCH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Gallino

31. Date filed (Month, Day, Year)

8/04

egistrar's Signature

Prince

State

Registrar

Gerald P. Sterner, M.D., 19 Chesapeake Beach Road E., Owings, MD 20736 32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

			For State Registrar		-	epartment of F Certificate of	Death	Reg	. No. 2	7 [399]		
	Physici /Medic		 Decedent's Name (First, Middle, Las Eugene Edward Kow 				2	2. Date of Death Month 04/10	Day Ye	3. Time of Death 6:15ath		
	Examin	er	4a. Facility Name (If not institution, give Anne Arundel Medic	·		4b. City, Town, o	Location of Death		4c. County of Death Anne Arundel			
	Funeral Director		134-34-0201	ex 7. Age ((In yrs. last birth 63 Y	Months Dave	Hours Min.	B. Date of Birth (Month, Day, Y 7/17/194	'ear)	9. Birthplace (State or Foreign Country) NewYork		
	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Anne Aru		Arnolo					10d. Inside City Limits 1 ☐ Yes 🍇 📆 No		
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to of Heelin and Mental Hygiene. It of Heelin and Mental Hygiene. or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 1182 Palmwood CT 11. Marital Status	Arnold, I			21012			t Country?		
9000	ours after o Iral", or iten Examiner	by	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	orced Year or Dates: 1965 edent's Education highest grade completed)		1 □ Yes ŽŽ No	Vas Decedent of Hispanic Origin? (Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☐ Yes Opecify:			White, etc. White		
21215-0036	within 72 h ene. than "natu h Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			6a. Decedem's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney			bb. Kind of Business/Industry Law/LegalAid			
land 2	uld be filed Aental Hygi rked other tic event, t	To Be Co	17. Father's Name (First, Middle, Last) Francis Kowalczuk				18. Mother's Name (First, Middle, Ma	iden Surname)			
, Maryland	and 2 sho leelth and N m 27 Is ma her trauma		19a. Informant's Name/Relationship (7 Kathryn Kowalczuk		118	Mailing Address (Street B2 Palmwood	Ct. Arno	1d, MD 2	21012			
Baltimore,	permit. Pages 1 and Department of Heelt Important: If Item 2: any Injury or other 1		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		Disposition (Name of crematory or other pla	04/13/	2007 Ba	20c. Location - City or Town, State Baltimore, MD			
Bal	Depa Impo any li		21. Signature of Funeral Service (Ren		_		Ave. Anna	polis, N	4D 21401	ome, P.A.		
	Physician /Medical		23a. Part1. Enter the disease, or dome shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the cause on each line a. Sepsis			ng, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death		
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
68760,	tificate be executed ig physician end as the burial-transit	edical Exa										
. Box	death cer e attendir d for use	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pl 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у	23d. Date of Month	23d. Date of delivery Month Day Year			
	requires that the een signed by th hould be detache	by	Part II. Other significant conditions of	ontributing to death but	ven in Part I.	23e. Did toba 1 ☐ Yes	A	co use contribute to the cause of death? 20 No 3 Probably 4 Unknown				
l Rec	The la ate has page 2	Completed	ruptured a	ebdomina	1 000	tic anei	rysm	24a. Was an autopsy performe	prio ed? dea	re autopsy findings available r to completion of cause of th? Yes 2 □ No		
or Vita	j Physician: Th er thìs certificate eral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Ti		4 U Nursing Hom		ce 6 Other (Specify)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined		y - At home, farr		Yes 2 □No	If. Location (Stre City or Town,		or Rural Route Number,		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifying Ph (Check only one) Certifying Ph	ysician: To the best of niner: On the basis of e and manner state	examination and	death occurred at the ti /or investigation, in my	ime, date and place, ar opinion, death occurre	nd due to the cau d at the time, dat	use(s) and manne te and place, and	er as stated. I due to the cause(s)		
	To To Con	Z	29b. Signature and title of certifier	290	29d. Date signed (Month, Day, Year) 4/10/0-7							
	5+1			Olexa	AAU	nc						
	Sta Regist	ar	31. Date filed (Month, Day, Year) APR 1 3	2007 32. Hegitrar	s signature	Specific						

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ORIGINAL

		,	1 - State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of I		-	giene	,	υĴ	95
			Decedent's Name (First, Middle, Last)					2. Date of De		3	3. Time of D	Death
	Physici			Lynott				Month April	Day	Year	:55	рм
ritir	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of D		4c. County			
			Montgomery Genera	al Hospita	1	Oln	ev		Mon	tgomer	v	
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday	If Under 1 Year	If Under 24		th	9. Birthplac		r Foreign
	Director		185-24-9493 X]M 2□F -	77 Yrs.	Months Days	Hours	March 1			sylva	
	P .		Usual Residence of Decedent									
	irylar	_	10a. State 10b. County		10c. City, Town or L	ocation				10d.	Inside City	_
	e Ma	cto	Maryland Montgor	nery	Sil	ver Spri	ng				1 🗌 Yes	21/2 NO
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country	?	
	ath w		704 Marshall Mand	or Drive		20	905		USA			
	within 72 hours after deeth with the Maryland ene. than "natural", or lleme 28a or 28a-1 show the Maryland at	Funeral	11. Marital Status	Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	- 14. Race Blac	e - American k, White, etc.		
98	or it	Į,	1 ☐ Never Married 2 ☑ Married	1 ∐ Yes ≵(∑ N If Yes, Give	0	1 ☐ Yes 2 ☑ No				White		
21215-0036	urai	d by	3 Widowed 4 Divorced	Year or Dates:								
Ϋ́	nat	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give	edent's Usual Occu	during most of	working	16b. Kind of Bu	isiness/Indus	try	
12	Mithir noe. than	E G	Elementary/Secondary (0-12)	College (1-4or 5-	+)	DO NOT use retire	<i>(</i> 0)					
7	Hygie Theri		17. Father's Name (First, Middle, Last)		EX	ecutive	18 Mother's	Name (First, Middle		ructio	n	
and	d d d	Be	Joseph A. Lynott			7		Thornton	, maiden obman	6/		
Ž	hould d Me mark matic	Ļ	19a. Informant's Name/Relationship (Ty	and Print)	10h Mail			r Rural Route Numb	os Citu os Tour	State 7in Ca	orla 1	
Maryland	d 2 sin and 7 is r				1							
e,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mantal Hygiene. Important: if Item 27 is marked other than "natural; or Iteme 23a or 28a-f show any injury or other treumatic event, the Modical Examinar mast be notified at once.		Mary T. Lynott/V 20a. Method of Disposition	Vife	20b. Place of Disp	4 Marsha	Ll Manoi	r Drive, S	Silver Si	pring,	MD 2	<u> 20905</u>
٥	or o		15 Burial 2 ☐ Cremation 3 ☐ R	lemoval from State	cemetery, cre	matory or other pla	· 1	April 19	Eoo. Coodion	Only or Town	, Otalo	
altimore,	tmer rtent rtent		4 Donation 5 Other (Specify)		Gate of			2007	Silver		. Mar	cylan
Bal	Sepa Depa Topo Topo Topo Topo Topo Topo Topo To		21. Signature of Funeral Service License	e /	/ F	2 Name and Addr rancis	ess of Eacility COII:	ins Funera	al Home	Inc.		
_	TO E & G		Gra D	y cerl	5	00 Univer	sity B	lvd, W., S	Silver Sp	pring,	MD 2	20901
			23a. Part1. Enter the dispase, or compleshock, or heart failure. List only or	re cause on each line	ine death. Do not en 9.	ter the mode of dy	ing, such as car	diac or respiratory a	rrest,	In	proximate terval Betw nset and De	veen
	Physician		Immediate Cause (Final disease or condition	ATHERO	SCLEROTI	i CARDIO	VASC41	lar Dise	45e	1	40 11	ears
	/Medical Examiner		resulting in death)		consequence of):						1	
	LAdiminei		Sequentially list conditions,									
	si ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
	and tran	Cam	that initiated events resulting in death) Last	Due to (er es e								
90,	cian surial	û		Due to (or as a	consequence of):							
8760,	cete be executed physician and the burial-transit	dlcal		j								
9 ×			IF FEMALE:	2- #								_
P.O. Box	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	Fetal death 3	Ectopic pregnanc	çy		23d. Dat Mor	e of delivery oth Da	v Y	'ear
<u>.</u>	the e	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at t 9 Unknown	ime of death 5	Other (specify) _					,	
<u>.</u>	that the death certif ed by the ettending detached for use as	P.	Part II. Other significant conditions cor	atshuting to doub hu	t not soculting in the	underhien en une m	use in Cost I	220 Did 1	obacco use contr	ibuto to the a	augo of do	ooth?
Vital Records,	Attending Physicien: The law requires that the death certific robath. robath. sctor: After this certificate has been signed by the ettending is got the funeral director, page 2 should be detached for use as	Completed by Physician/Me		ryctive		DISEAS		1/2		3 Probabl		
5	neen	ted	1	401100	Lune	VISEMS	12	-	165 2 100		, 4	TIKITOWIT
ဝ	has b	현	HNEMIA					24a. Was	an 24b. V	Vere autopsy prior to compl	findings a	ivailable ause of
<u> </u>	The ete t page	5						perfo 1 ☐ Yes	ormed?	leath? □Yes 2[
<u>=</u>	ilcien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?				26. Place of	Death (Check only of	one)			
~	Physic this co	္	1 Dres 2 No	lospital: 1 🗆 Inpatier		nt 3 DOA	her: 4 🗌 Nursir	ng Home 5 🗆 Resi	dence 6 Othe	er (Specify)		
0	ng P fter ti	ä	27. Manner Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o		ry at ork?	28d. Describe	how injury occurr	ed		
Ö	endii sath. or: A he fu	atle	2 Accident investigation			M 1]Yes 2□No					
Division of	r Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm, st (Specify)	reet, factory, office		28f. Location (Street and Number	er or Rural R	oute Numb	ber,
Ω	ital c irs ef ral Di led ir	Se		1								
	To the Hospital or Attending Physicien: The i within 24 hours efter death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Ca	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best o	f my knowledge, dea examination and/or in	th occurred at the t	ime, date and p	lace, and due to the	cause(s) and ma	nner as state	id.	
	the Prin 24	Medical	one)	and manner stat	ed.							
•	CO Test	2	29b. Signature and title of certifier	mo			se number		29d. Date signed		y, Year)	
	8		your ge	11111		D00	30416	4	APRIL	15	200	27
			7 / /									
			30. Name and address of person who co		ath (Item 23a) (Type	Print)						
			30. Name and address of person who co 30. HW HERRING 31. Date filed (Month, Day, Year)	MD . 18	ath (Item 23a) (Type 101 PRINC. 's Signature	Print)	Der, OL	NEY, MD	2083	2		

			1 - For State Registrar	State	of Marylar	•	artment of rtificate o		and Menta	al Hygier Reg. 1	ZUU_{i}	13999
	Physici	an	1. Decedent's Name (First, Middle, L	Louise	Lovia				Mo	te of Death	20 20°	3. Time of Death
and.	/Medic Examir		4a. Facility Name (If not institution, gi				4b. City, Town	or Location		pru	4c. County of D	
	CXAIIII	161	Fahrney-Keedy Me					sboro				ngton
	Funeral			Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye			e of Birth onth, Day, Yea		Birthplace (State or Foreign Country)
	Director		212 30 7003	1□M 2□ X	84	Yrs.	Months Da	/s Hours	Min. May	31,19	22 M	aryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	Maryli f sho	ō	,	aton								1 ☐ Yes 2 ☐ No
	the 1286	Director	Md. Washin 10e. Street and Number	.g con		Smith	10f. Zip Cod	9		10g.	Citizen of What	
	h with		12803 Rowe Rd.				,	21783				.s.A
	deatl	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	J.S. 13.	Was Decedent		rigin? (Specify Ye	s or No-	14. Race - A	merican Indian,
ð	or Ite		1 Never Married 2 Married	1 ☐ Yes If Yes, G	2 J No		1 ☐ Yes 2 ⊡yi			eic.)	Specify:	/hite, etc.
9500-6121	hours ural',	d by	3 XWidowed 4 □ Divorced	Year or l	Dates:	1			•			White
ပ ု	n 72	lete	15. Decedent's 1 (Specify only highest g)	(Give	dent's Usual Oc kind of work do DO NOT use rei	ne durina mos	st of working	16b.	Kind of Busine	ess/Industry
7.	withi iene. then	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		Cool	,			Healt	h Services
פ	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28e-f show event, the Medical Evanting must be notified at	Be C	17. Father's Name (First, Middle, Las	t)					er's Name (First,	Middle, Maid	en Sumame)	
Maryland	es 1 and 2 should be fi of Health and Mental F if Item 27 is marked ot ir other treumatic ever	To E	Elmer D. Kli	ne					Margie	M. Sm	ith	
a	2 sho		19a. Informant's Name/Relationship	(Type, Print)					er or Rural Route			e, Zip Code)
_	and fealth om 27 ther ti		Richard G. Lewis 20a. Method of Disposition	(Son)	20h (agerstow.			
Baitimore,	Pages nent of H int: If Ite		1 Burial 2 □ Cremation 3	☐Removal from	1 State		sition (Name of natory or other)	127	April 25		Location - City mithsbu	
	permit. Page Department of Importent: If any injury or once.		*4 Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		Sm:		o Cemet		2007			
ä	Dep den de de de de de de de de de de de de de		Jally /	7	ie Ma				•			ury Ave. Md. 21783
			23a. Part 1. Enter the disease, or con	nplications that	caused the deat						isburg,	Approximate
	Physician		shock, or heart failure. List ont Immediate Cause (Final disease or condition	\cap		Cod						Interval Between Onset and Death
	/Medical		resulting in death)		enmon (or as a consec	quence of):	20.					101)
	Examiner		Sequentially list over the es	b	ahetro	. M	ellit	15				204
	sit a	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):						,		
	xecuti and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a c n e	uen = of):						165
g/20	death certificate be executed e attending physician and nd for use as the burial-transit	dicai E				,						in.
200	ificate g phy as the			Q								
o n	eath certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Ectopic p <i>r</i> egna				23d. Date of	delivery
ה מ	ed for	hysician/M	in the past 12 months?		nant at time of c		Other (specify)				Month	Day Year
r Ö	v requires that the de been signed by the should be detached	Phy	9 Unknown									
JS,	requires that een signed b nould be deta	by	Part II. Other significant conditions	contributing to d	death but not res	suiting in the u	nderlying cause	given in Part I	l. 23	ie. Did tobacc	_	e to the cause of death? Probably 4 2 Noknown
Sold	requ been should	etec							"			
d)	has has	ompleted							24	 a. Was an autopsy performed 	prior	autopsy findings available to completion of cause of n?
		ပိ	25. Was case referred to medical	<u> </u>						Yes 2		res 2□No
5	S E	0 0	examiner?	Hospital:	Inpatient 2	ER/Outpatier	it 3 DOA	Than	e of Death (Checursing Home 5		6 MOther /6	Progify)
_	On 0 0	Ë	27. Manner of Death	28a. Date		28b. Time of	28c. lr	jury at Vork?	_		jury occurred	ipecity)
DIVISION	Attending r death. sctor: After sy the fune.	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigate	on	, , , , , , , , , , , , , , , , , , ,	injury		Yes 2	No			
	F 0 E C	ertification;	3 Suicide 6 Could not 4 Homicide determine	4 200. Flac	e of Injury - At h ding, etc. <i>(Speci</i> i	ome, farm, str fy)	eet, factory, offi	9		cation (Street y or Town, St		Rural Route Number,
_	pitel o	0	CO. C. William A. D. C. William B.	husiaise T. II.								
	Hos 24 ho Fun etely f	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	iminer: On the l	le best of my kno basis of examina nner stated.	ation and/or in	occurred at the vestigation, in m	y time, date ar y opinion, dea	nd place, and due ath occurred at th	e to the cause to time, date a	(s) and manner and place, and	r as stated. due to the cause(s)
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Me	29b. Signature and title of certifier				29c. Lice	ense number		29d. l	Date signed (M	onth, Day, Year)
)	2	- Andrews		D	232	7	64	1-23-	2007
	(2)		30. Name and address of person who	completed cau	use of death (Iter	m 23a) (Type,		0,0				
			Khalid Waseem M.	D. 1126	Opal C	t. Hag	erstown	Md. 2	1740			
	Sta Registi		31. Date filed (Month, Day, Year)	2007 32.	gistrar's Signa	ature A	9-03-					
				Feel	The state of the state of	55 16	BRADS P					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12:05 ам Sylvia 5 1 Margolis April 9, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8604 Fenway Drive Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2 🕱 F Yrs. 85 Director 217-16-5702 September 6,1921 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fehow r than "natural", or items 23e or 28e-f eho the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Florida Palm Beach Singer Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33404 5080 N. Ocean Drive, Apt. 9A North U.S.A. filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Maritaf Status 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify Completed by 3 Widowed 4 Divorced Caucasian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Heelth and Mental Alex Greenberg Minna Silverman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itsm 27 i Tevis Margolis - Husband 5080 N. Ocean Drive, Apt 9A North, Singer Island, FL 33404 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: if its eny injury or o cemetery, crematory or other place) 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/11/2007 Falls Church, Virginia King David Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc Myphis Illever 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ysicien and le burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical the IF FEMALE: use 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 □Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ned by the a detached f 1 ☐ Yes 2 🗷 No 9☐ Unknown 9 Unknown Part If. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖾 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA ě 1 ☐ Yes 2 🕱 No After the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 XNaturat 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident tor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 Homicide To the Hospital within 24 hours a To the Funeral I filled 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0064615 April 10, 2007 Krow W 30. Name and address of person o complet cause of de h (Item a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)
APR 17



